Consent to communicate with a health professional

Family physician, specialist, pharmacist, other

Name	Title	Institution / telephone

I hereby agree to allow the dentist and his or her staff to obtain information that is relevant to or consistent with the purpose of the file from the health professionals listed above or to disclose such information to these health professionals.

Signature of the patient or designated representative ____________ Date ____________

Consent and identification

I have filled out this medical-dental questionnaire to the best of my knowledge.

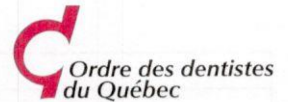
Signature of the patient or designated representative ____________ Date ____________

- Patient him/herself ☐
- Parent/guardian (if under 14 yrs. old) ☐
- Legal/authorized representative ☐
- Other ☐

Mr. ☐ Ms. ☐ ____________ Name in print

I have reviewed the medical-dental questionnaire and indicated all changes.

Signature	Date YY/MM/DD	Signature	Date YY/MM/DD
Signature	Date YY/MM/DD	Signature	Date YY/MM/DD
Signature	Date YY/MM/DD	Signature	Date YY/MM/DD
Signature	Date YY/MM/DD	Signature	Date YY/MM/DD



CONFIDENTIAL MEDICAL-DENTAL QUESTIONNAIRE

A patient's dental file contains information on the care provided to the patient. It is protected by law and professional secrecy and kept at the dental office, where only the dentist and his or her staff have access to it. Patients are also entitled to access their file and make corrections.

Personal Information

First name ____________

Last name ____________

Sex F ☐ M ☐

Date of birth YY/MM/DD

Health Ins. No. ____________ Expiry YY/MM

Address ____________

City ____________

Province ____________ Postal code ____________

Contact Information

Home tel. ____________

Work tel. ____________

Cell phone ____________

E-mail ____________

For emergencies, call:

Name ____________

Relationship to patient ____________

Main tel. ____________

Cell phone ____________

Dental Information

Reason for today's visit ____________

Do you fear dental treatments?

Not at all ☐ A little ☐ Very much ☐

Specify ____________

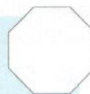
Last visit 0-6 months ☐ 6-12 months ☐ + than 12 months ☐

Treatment(s) received ____________

	Yes	No
With panoramic radiographs (large x-ray)	☐	☐
With intraoral radiographs (small x-rays)	☐	☐

This questionnaire will help the dentist and his or her staff provide the best possible care and reduce the risk of medical complications. It is in the patient's best interest to carefully fill it out and notify the dentist of any change in their health condition.

Patient ____________________



Operative precautions–For use by the professional

Medical history

	Yes	No	
1. Would you like to speak privately with your dentist?	☐	☐	**Reason, details and date**
2. Are you being treated by a physician?	☐	☐	____________________
3. Have you ever had surgery or been hospitalized?	☐	☐	____________________
4. Do you have joint prostheses (hip, knee, etc.)?	☐	☐	____________________
5. Have you gained or lost a lot of weight recently?	☐	☐	____________________
6. Are you pregnant?	☐	☐	
7. Are you breastfeeding?	☐	☐	
8. Are you taking natural or homeopathic products?	☐	☐	Specify ____________________
9. Are you taking medication?	☐	☐	
10. Are you taking birth control ☐ or hormones ☐ ?	☐	☐	

Please indicate all medication (including birth control and hormones) that you are taking or have taken in the last 12 months

Medication and reason	Medication and reason

Please check Yes or No for each current or past condition

	Yes	No
Blood disorders (hemophilia, anemia, prolonged bleeding)	☐	☐
Heart conditions		
Infarction (heart attack), angina, surgery, etc.	☐	☐
Heart infection (endocarditis)	☐	☐
Surgery to replace or repair a valve /cusp	☐	☐
Blood pressure high ☐ low ☐	☐	☐
Dizziness, fainting	☐	☐
Frequent headaches	☐	☐
Jaw pain	☐	☐
Liver disorders (hepatitis A, B, C. cirrhosis, etc.)	☐	☐
Digestive system disorders or diseases	☐	☐
Specify ____________________		
Stomach disorders ulcer ☐ reflux ☐	☐	☐
Kidney disorders	☐	☐
Diabetes	☐	☐
Thyroid disorders	☐	☐
Cancer (tumour) Specify ____________________	☐	☐
Radiotherapy	☐	☐
Chemotherapy	☐	☐
Do you suffer from dry mouth?	☐	☐
Sexually transmitted or blood-borne infections (STBBI)	☐	☐
Specify ____________________		

	Yes	No
Skin diseases	☐	☐
Eye disorders	☐	☐
Earaches	☐	☐
Arthritis	☐	☐
Osteoporosis	☐	☐
Prevention / treatment (e.g.: tablets)	☐	☐
Annual or monthly injection	☐	☐
Chronic pain	☐	☐
Epilepsy	☐	☐
Nervous system disorders or diseases	☐	☐
Mental disorders or illnesses	☐	☐
Frequent colds or sinusitis	☐	☐
Tuberculosis or lung disorders	☐	☐
Asthma	☐	☐
Hay fever / seasonal allergies	☐	☐

Allergy or manifestation with products containing:

	Yes	No		Yes	No
Latex	☐	☐	Sulfonamides	☐	☐
Penicillin	☐	☐	Anesthetic	☐	☐
Other antibiotics	☐	☐	Food	☐	☐
Codeine	☐	☐	Iodine-containing products	☐	☐
Aspirin	☐	☐	Other: ____________	☐	☐

Other medical conditions that should be mentioned: ____________________

____

Other aspects

	Yes	No
Do you snore?	☐	☐
Do you suffer from sleep apnea?	☐	☐
Do you smoke? _____ cig./day or ex-smoker ☐	☐	☐
Do you drink alcohol?	☐	☐
Frequency: _____ drinks ☐ /day ☐ /week ☐ /month	☐	☐
Do you take drugs?	☐	☐
Do you take methadone?	☐	☐

Section reserved for the dentist's special notes

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