ACDQ
ASSOCIATION DES CHIRURGIENS DENTISTES DU QUÉBEC

CONFIDENTIAL QUESTIONNAIRE OF INTRODUCTION

Ordre des Dentistes du Québec

Sex: M ❑ F ❑ Last Name: _____ First Name: _____

Address: N°: _____ Street: _____ Apt.: _____ City: _____

Postal Code: _____ Tel. Res.: _____ Work: _____ (Ext.): _____ E-mail address : _____

Birthdate: Day: _____ Month: _____ Year: _____ Guardian: _____

Medicare N°.: _____ Expiry Date: _____ Social Insurance N°. (optional): _____

Referred by: _____ Motive for visit: _____

MEDICAL HISTORY

Weight _____ Height _____

	Yes	No
1. Are you presently under a doctor's care?	❑	❑
If yes: Last Name: _____ First Name: Tel.: _____ (Ext.): _____		
2. Are you presently taking any drug or medication, or have you taken any in the last six months?	❑	❑
If so, which:		
3. Did you recently experience a significant weight loss or gain?	❑	❑
4. Are you pregnant?	❑	❑
5. Are you taking any birth control pill?	❑	❑
Are you suffering or have you ever suffered from:		
6. Heart disease (stroke, angina, valvular problems, murmur)	❑	❑
7. Rheumatic fever	❑	❑
8. Prolonged bleeding	❑	❑
9. Anemia	❑	❑
10. High ❑ Low ❑ Blood pressure	❑	❑
11. Frequent colds or sinusitis	❑	❑
12. Tuberculosis or lung problems	❑	❑
13. Digestive problems	❑	❑
14. Stomach ulcer	❑	❑
15. Liver disease (hepatitis A, B, C, cirrhosis, etc.)	❑	❑
16. Kidney disease	❑	❑
17. Venereal Disease (V.D.)	❑	❑
18. Diabetes	❑	❑
19. Thyroid problems	❑	❑
20. Skin disease	❑	❑
21. Eye problems	❑	❑
22. Arthritis	❑	❑
23. Epilepsy	❑	❑
24. Nervous disorders	❑	❑
25. Frequent headaches	❑	❑
26. Dizzy spells or fainting spells	❑	❑
27. Earaches	❑	❑
28. Hay fever	❑	❑
29. Asthma	❑	❑
30. Do you smoke?	❑	❑
31. Have you ever had radiotherapy or/and chemotherapy treatments (tumor)?	❑	❑
32. Do you have AIDS symptoms?	❑	❑
33. Are you an AIDS virus carrier?	❑	❑
34. Do you have artificial joints (knee, hip, etc.)	❑	❑

35. Do you have any of the following allergies?

	Yes	No		Yes	No
Food	❑	❑	Iodine	❑	❑
Penicillin	❑	❑	Sulfonamides	❑	❑
Other antibiotics	❑	❑	Codeine	❑	❑
Specify: _____			Local anaesthesia	❑	❑
Aspirin	❑	❑	Others _____		

	Yes	No
36. Were you ever hospitalized or have you undergone surgery other than dental?	❑	❑
If so, indicate which one and when:		
_____ date _____		
_____ date _____		
_____ date _____		
37. Is there anything concerning your health you wish to discuss privately with your dentist?	❑	❑
Remarks: _____		

FOR THE PHYSICIAN'S USE ONLY

PRECAUTIONS:

DENTAL HISTORY

Last visit: 0-6 months ❑ 6-12 months ❑ 12 months + ❑

Treatments received: _____

Have you previously had dental treatments such as:	Yes	No
1. Oral hygiene instructions	❑	❑
2. Gum treatment	❑	❑
3. Orthodontic treatment	❑	❑
4. Root canal treatment	❑	❑
5. Dental fillings	❑	❑
6. Crown or/and bridge	❑	❑
7. Partial or/and complete denture	❑	❑
8. Surgical treatment or extraction	❑	❑
9. Dental implants	❑	❑
10. X-rays	❑	❑
11. Others	❑	❑

I, the undersigned, hereby declare that I have read, understood and answered the above medical-dental questionnaire to the best of my knowledge. I also hereby promise to inform you of any change to my health. I authorize the setting up of my dental file, its follow-up, as well as my registration on the recall list(s) of the attending dentist(s). I have been informed that my file will be kept in the office at all times and that only the dentist(s) and his/her (their) auxiliary personnel will have access to it. I have also been informed of my right to consult my file, to request that it be corrected, if necessary, and to remove my name from the recall list.

Signature: _____ Date: _____
Patient or guardian

I acknowledge that I have read the answers to the above questionnaire and that I have taken the customary measures, as the case may be.

Signature: _____ Date: _____
Attending dentist

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