Medical Form

* Patient Full Name: ______________________________ * Birthday : ___________________________
* Phone Number: _________________ * Email: ____
* Adress: ____
* RAMQ Number ________________________________
* Are you under a doctor's care Yes ▢ No ▢

*** Do you or have you suffered from**

Heart Ailments	Yes ▢ No ▢	Rheumatic Fever	Yes ▢ No ▢
High / Low Blood Pressure	Yes ▢ No ▢	Asthma	Yes ▢ No ▢
Anemia	Yes ▢ No ▢	Tuberculosis, Lung Ailments	Yes ▢ No ▢
Diabetes	Yes ▢ No ▢	Liver Problems, Hepatitis, Cirrho	Yes ▢ No ▢
Kidney Problems	Yes ▢ No ▢	Venereal Disease	Yes ▢ No ▢
Aids	Yes ▢ No ▢	Eye Trouble	Yes ▢ No ▢
Arthritis	Yes ▢ No ▢	Epilepsy	Yes ▢ No ▢
Nervous Complaints	Yes ▢ No ▢	Thyroid Trouble	Yes ▢ No ▢
Digestive Problems	Yes ▢ No ▢	Prolonged Bleeding	Yes ▢ No ▢
Stomach Ulcer	Yes ▢ No ▢	Do you have artificial joints ?	Yes ▢ No ▢
Frequent Headaches	Yes ▢ No ▢	Loss of consciousness	Yes ▢ No ▢
Ear Infections	Yes ▢ No ▢		

*** Do you suffer from allergies**

Hay Fever	Yes ▢ No ▢	Penicillin	Yes ▢ No ▢
Aspirin	Yes ▢ No ▢	Sulfamides	Yes ▢ No ▢
Local Anesthetics	Yes ▢ No ▢	Other Antibiotics	Yes ▢ No ▢
Other Allergies	Yes ▢ No ▢		

* Are Pregnant Yes ▢ No ▢ * Are you scared of dental treatments Yes ▢ No ▢
* Are you pleased with your smile ? Yes ▢ No ▢
* What would you like to change ? ____
* Do you take birth control pill, contraceptive ? Yes ▢ No ▢
* Do you take medication ? Yes ▢ No ▢

List of present medication ____

* Are you a smoker ? Yes ▢ No ▢
* Have you received radiotherapeutic treatments ? Yes ▢ No ▢
* Surgery Name ______________________ * Surgery Date ___________________________________
* Dental History ____
* When was your last dental appointment ? _________________________

*** Have you had** ▢ Teeth extraction / oral surgery ▢ Dental xrays
▢ Gum Treatments ▢ Hemorrhaging ▢ Orthodontic treatments ▢ Root canal work

*** Do you have** ▢ Pain / Difficulty when opening your mouth ? ▢ Bleeding of gums
▢ Unreplaced missing teeth ▢ Loose teeth

* Do you snore ? Yes ▢ No ▢
* Referral ______________________________ * Referred By __________________________________
* Reason for visit ___________________________

*** Payments** ▢ Self ▢ Insurance ▢ RAMQ ▢ Other
* Insurance Company ________________________ * Policy Number __________________________
* Identification Number _______________________

Date: .... Patient Signature: …………………………… Dentist: ………………………………….