

**PERSONAL AND CONFIDENTIAL INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ SEX : F M

BIRTH DATE: Year: \_\_\_\_\_ Month: \_\_\_\_\_ Day: \_\_\_\_\_ GUARDIAN: \_\_\_\_\_

ADDRESS: No: \_\_\_\_\_ Street: \_\_\_\_\_ Apt.: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

PHONE. : Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

IN CASE OF EMERGENCY, contact: \_\_\_\_\_ Tel.: \_\_\_\_\_

No RAMQ: \_\_\_\_\_ Exp. : Day: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

REASON OF VISIT: \_\_\_\_\_

DISABILITIES AND LIMITATIONS: Wheelchair Cane Medical Walker The patient must be accompanied

Physical disability: \_\_\_\_\_

Antibiotic Prophylaxis Required: YES NO

**MEDICAL HISTORY**

		YES	NO	Do you suffer or have you suffered from:	YES	NO
1.	Are you currently under the care of a doctor?..... If Yes Last name: _____ First name: _____ Specialty: _____ Frequency of follow-ups: _____ Reason: _____			9. Cardiac disorders (infarction, angina, arrhythmia, heart murmur endocarditis, valve disease) .....		
2.	Are you taking or have you taken in the last 6 months any medicines, natural or homeopathic products? .....			10. Blood pressure disorders (high or low) .....		
	If so, complete the "Drug History" table on the back			11. Vascular disorders (stroke, thrombophlebitis) .....		
3.	Have you had a fever over 38 ° C in the past week? .....			12. Blood disorders (hemophilia, anemia, mononucleosis) .....		
4.	Have you been hospitalized for the past 2 years? .....			13. Lung disorders (asthma, emphysema, tuberculosis, COPD) .....		
	If Yes Reason: _____ Year: _____			14. Liver problems (jaundice, hepatitis A B C, cirrhosis) .....		
	Reason: _____ Year: _____			15. Digestive disorders (reflux, stomach ulcer, Crohn's disease) .....		
	Reason: _____ Year: _____			16. Endocrine disorders (hypothyroidism, hyperthyroidism) .....		
5.	Do you use tobacco, drugs, alcohol? .....			17. Kidney problems (failure, kidney stones) .....		
6.	During the past 6 months, have you had:			18. Neurological disorders (epilepsy, parkinson's, multiple sclerosis) .....		
	Tattoo Acupuncture			19. Cognitive and learning disorders (HAT, ADHD, autism, PDD) .....		
	Permanent makeup Electrolysis			20. Psychiatric disorders (depression, anxiety, schizophrenia, bipolar personality disorder, borderline personality disorder) .....		
	Body piercing Injury with a contaminated needle			21. Inflammatory diseases (arthritis) .....		
7.	Women:			22. Infections transmissible through blood and saliva (STBBI / STD) .....		
	Are you pregnant? .....			23. Rheumatic fever .....		
	If so, how many weeks _____			24. Diabetes (Type I or II) .....		
	Are you taking birth control medications? .....			25. Sinusitis, chronic rhinitis .....		
	Are you postmenopausal? .....			26. Glaucoma		
8.	Have you ever had an allergic reaction to the following products:			27. Cancer .....		
	Latex .....			If Yes Localization: _____ Year: _____		
	Aspirin .....			Treatments: _____		
	Penicillin .....			28. Have you had a transplant? .....		
	Food .....			29. Do you have one or more joint prostheses? (hip, knee) .....		
	Others .....			If so, for how many days? _____		
				30. Do you follow a special diet? .....		
				31. Do you have acute immunodeficiency syndrome (AIDS)? .....		
				32. Are you HIV positive? .....		
				33. Frequent headaches, migraines .....		
				34. Loss of consciousness, dizziness .....		
				35. Abnormal weight loss or gain, anorexia, difficulty swallowing .....		
				36. Fatigue or significant stress .....		

I, the undersigned, declare that I have read, understood, have informed myself and answered the medical questionnaire to the best of my knowledge. I hereby agree to notify you of any changes in my health. I hereby authorize the constitution of my dental hygiene file. I have been informed that my file will be kept at all times at the attending dental hygienist's office and accessible only to the dental hygienist team. I have also been informed of my right to consult my file at all times and request a correction if necessary.

Signature of patient / Responsible: X \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge that I have read the answers entered in the medical questionnaire and have taken the necessary precautions, if necessary.

Signature of dental hygienist: X \_\_\_\_\_ Date: \_\_\_\_\_

