DR NAGY BRADY
Chirurgien dentiste

ACDQ ASSOCIATION DES CHIRURGIENS DENTISTES DU QUÉBEC

CONFIDENTIAL QUESTIONNAIRE OF INTRODUCTION
WELCOME TO OUR OFFICE

PLEASE PRINT

Last name: _____ First name : _____ Date of birth : _____

Address : _____

E-Mail Address : _____

Telephone : Home _____ Work _____ ext _____ Mobile _____

Dental insurance : Yes □ No □ Name of insurance company : _____ Policy : _____

Certificate : _____ You are refered by : _____

MEDICAL HISTORY

	YES	NO
Are you presently under a doctor's care ?	☐	☐
If so reason: _____		
Are you presently taking any drug or medication, or have you taken any in the last six months?	☐	☐
If so, which? _____		
Are you pregnant?	☐	☐
Are you taking any birth control pill?	☐	☐
Are you suffering or have you ever suffered from :		
* Heart disease	☐	☐
(stroke, angina, valvular, problems, murmur)?	☐	☐
* Rheumatic fever	☐	☐
* Prolonged bleeding	☐	☐
* Anemia	☐	☐
* Blood pressure High □ Low □	☐	☐
* Frequent colds or sinusitis	☐	☐
* Tuberculosis or lung problems	☐	☐
* Digestive problems	☐	☐
* Stomach ulcer	☐	☐
* Liver disease (hepatitis A, B, C, cirrhosis, etc.)	☐	☐
* Kidney disease	☐	☐
* Venereal disease	☐	☐
* Diabetes	☐	☐
* Thyroid problems	☐	☐
* Skin disease	☐	☐
* Eye problems	☐	☐
* Arthritis	☐	☐
* Epilepsy	☐	☐
* Nervous disorders	☐	☐
* Frequent headaches	☐	☐
* Dizzy spells and fainting spells	☐	☐
* Earaches	☐	☐
* Hay fever	☐	☐
* Asthma	☐	☐
Do you smoke?	☐	☐
Have you ever had radiotherapy or / and chemotherapy?	☐	☐
Do you have AIDS symptoms?	☐	☐
Are you an AIDS virus carrier?	☐	☐
Do you have artificial joints (knee, hip, etc.)?	☐	☐

MEDICAL HISTORY

Do you have any of the following allergies :

	YES	NO		YES	NO
Food	☐	☐	Sulfonamides	☐	☐
Penicillin	☐	☐	Codeine	☐	☐
Aspirin	☐	☐	Local anesthesia	☐	☐
Iodine	☐	☐	Latex	☐	☐
Other antibiotic	☐	☐	Others _____		

DENTAL HISTORY

Were you ever hospitalized or have you undergone surgery other than dental	☐	☐

If so, why and when

_____ date _____

_____ date _____

How often in a day do you brush your teeth? _____		
How often in a day do you floss your teeth? _____		
Do you grind your teeth at night?	☐	☐
Do you practice a sport that requires physical contact?	☐	☐
Do your gums bleed?	☐	☐
Have you ever had an orthodontic treatment?	☐	☐
Do you like the color of your teeth?	☐	☐
Are you happy with your smile?	☐	☐
Would you like to discuss possible treatments to improve your smile?	☐	☐

Do you fear dental treatments ?

a little ☐ a lot ☐ Not at all ☐

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

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 treating dentist(s).

I have been informed that my if 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 if be corrected, if necessary, and to remove my name from the recall list.

Signature _____ Date _____
(patient or guardian)