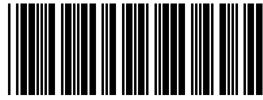
# DENTAL FILE – 1

## *CONFIDENTIAL QUESTIONNAIRE*



DT9135

| Date of birth (Year / Month / Day) | Room no. | File no. |
|---|---|---|

First and last name at birth

Usual name or spouse's name

Address

| Postal code | Telephone no. (area code) | Sex: M ☐ F ☐ |
|---|---|---|

| Health insurance no. | Name of attending physician |
|---|---|

| Area code | Telephone no. (work) | Extension | Weight | Height |
|---|---|---|---|---|

Guardian

Status: Married: ☐ Yes ☐ No ☐ Other

Referred by:

**MAIN COMPLAINT**

## HEALTH HISTORY

| Attending physician | Area code | Telephone no. |
|---|---|---|

*Indicate if:*

| | Yes | No |
|---|---|---|
| 1. You are presently under a doctor's care | ☐ | ☐ |
| 2. You are presently taking any drug or medication or have taken any in the last six months | ☐ | ☐ |
| If so, specify: | | |
| 3. You are pregnant | ☐ | ☐ |
| 4. You are taking contraceptive pills | ☐ | ☐ |
| *You are suffering or have suffered from:* | | |
| 5. Heart disease | ☐ | ☐ |
| 6. Rheumatic fever | ☐ | ☐ |
| 7. Prolonged bleeding | ☐ | ☐ |
| 8. Anemia | ☐ | ☐ |
| 9. High blood pressure | ☐ | ☐ |
| 10. Frequent colds or sinusitis | ☐ | ☐ |
| 11. Lung problems (Tuberculosis) | ☐ | ☐ |
| 12. Digestive problems | ☐ | ☐ |
| 13. Liver disease (hepatitis A, B, or C, cirrhosis, etc.) | ☐ | ☐ |
| 14. Kidney disease | ☐ | ☐ |
| 15. Venereal disease (STD) | ☐ | ☐ |
| 16. Diabetes | ☐ | ☐ |
| 17. Thyroid problems | ☐ | ☐ |
| 18. Skin disease | ☐ | ☐ |
| 19. Eye problems | ☐ | ☐ |
| 20. Arthritis – back problems | ☐ | ☐ |
| 21. Epilepsy | ☐ | ☐ |
| 22. Nervous disorders | ☐ | ☐ |
| 23. Frequent headaches | ☐ | ☐ |
| 24. Fainting spells | ☐ | ☐ |
| 25. Earaches | ☐ | ☐ |
| 26. Hay Fever – Asthma | ☐ | ☐ |

## HEALTH HISTORY (cont.)

*Indicate if:*

27. You have any of the following allergies:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Foods | ☐ | ☐ | Iodine | ☐ | ☐ |
| Penicillin | ☐ | ☐ | Sulfonamides | ☐ | ☐ |
| Aspirin | ☐ | ☐ | Others | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 28. You have had a reaction to anesthesia | ☐ | ☐ |
| 29. You have articular prostheses (hip, knee, etc.) | ☐ | ☐ |
| 30. You have had radio therapy and/or chemotherapy treatments (tumor) | ☐ | ☐ |
| 31. You are an AIDS virus carrier (HIV-infected) | ☐ | ☐ |

If so, specify: ☐ With symptoms ☐ Without symptoms

## DENTAL HISTORY

*Last visit:* ☐ 0-6 months ☐ 6-12 months ☐ More than 12 months

*Treatments received (specify):*

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| 1. Oral hygiene instruction | ☐ | ☐ | 7. Partial and/or complete dentures | ☐ | ☐ |
| 2. Gum treatment | ☐ | ☐ | 8. Surgical treatment or extractions | ☐ | ☐ |
| 3. Orthodontic treatment | ☐ | ☐ | 9. Dental implants | ☐ | ☐ |
| 4. Rootcanal treatment | ☐ | ☐ | 10. X-rays | ☐ | ☐ |
| 5. Dental fillings | ☐ | ☐ | 11. Others | ☐ | ☐ |
| 6. Crown(s) and/or bridge(s) | ☐ | ☐ | If so, specify: | | |

*Indicate if:*

You were hospitalized or have undergone surgery other than dental: ☐ No ☐ Yes

If so, indicate which ones and when:

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Remarks:

| I declare that I have answered the above questionnaire to the best of my knowledge. | Signature (patient or guardian) | Date (year, month, day) |
|---|---|---|