PARO IMPLANTO POINTE-CLAIRE

SPÉCIALISTES EN PARODONTIE | IMPLANTOLOGIE

DR DROUIN | DR TACHÉ | DRE NOCE | DR SHENOUDA

Last Name: _____ First Name _____ Gender: M ○ F ○

Address: _____ Apt.: _____ City: _____ Postal Code: _____

Tel. Home _____ Cell _____ Tel. Work _____

Date of Birth: _____ _____ _____ Email: _____
month year

Who should we thank for referring you to our office? Dr: _____ Other _____

What is the main reason for your visit? _____

	yes	no
1. Are you presently under a doctor's care?	○	○
2. Attending physician: Dr _____ Tel.: _____		
3. Are you presently taking any drugs or medication, or have you taken any in the last 6 months? _____	○	○
4. Are you taking any birth control pill	○	○
Are you pregnant?	○	○

Are you suffering or have you ever suffered from?

5. Heart disease (stroke, angina, valvular problems, murmur)	○	○
6. Rheumatic fever	○	○
7. Prolonged bleeding	○	○
8. Anemia	○	○
9. High ○ Low ○ Blood pressure	○	○
10. Frequent colds or sinusitis	○	○
11. Tuberculosis or lung problems	○	○
12. Digestive problems	○	○
13. Stomach ulcer	○	○
14. ●steoporosis :	○	○
15. Liver disease (hepatitis : A, B, C, cirrhosis, etc.)	○	○
16. Kidney disease	○	○
17. Sexually transmitted infections (S.T.I.)	○	○
18. Diabetes	○	○
19. Thyroid problems	○	○
20. Skin disease	○	○

	yes	no
21. Eye problems	○	○
22. Arthritis	○	○
23. Epilepsy	○	○
24. Nervous disorders	○	○
25. Frequent headaches	○	○
26. Dizzy spells and fainting spells	○	○
27. Earaches	○	○
28. Hay fever	○	○
29. Asthma	○	○
30. Do you smoke?	○	○
31. Have you ever had radiotherapy and/or chemotherapy (cancer)?	○	○
32. Are you an HIV carrier?	○	○
33. Do you have AIDS?	○	○
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	○	○	Sulfonamide	○	○
Other antibiotics	○	○	Codeine	○	○
Specify : _____			Local anasthesia	○	○
Aspirin	○	○	Others : _____		

Do you have any dietary restrictions (special diet, personal or religious)?

_____

Were you ever hospitalized or have you undergone surgery other than dental?
If so, indicate which ones and when?

_____ Year: _____

_____ Year: _____

_____ Year: _____

Precautions : _____

_____

_____

_____

_____

What could we do to make your visit in our office as pleasant as possible? _____

_____

This portion to be completed by the administration

I, the undersigned, hereby declare that I have read, understood and answered the above medical questionnaire to the best of my knowledge. I also hereby promise to inform you of any change to my health.

Patient	*Periodontist*	*Date*
_____	_____	_____

Click here to submit form

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