Note: This document was prepared by the ACDQ for information purposes and as a supplement to the FAQ available on our website at acdq.qc.ca.

Consent to communicate with a health professional
Family physician, specialist, pharmacist, other

Name	Title	Institution / telephone

I hereby agree to allow the dentist and his or her staff to obtain information about my health status from the health professionals listed above or to disclose such information to them for the purposes mentioned.

Signature of the patient or designated representative — Date

Dentist's signature on the questionnaire:

Dentists do not have to sign it. The confidential medical-dental questionnaire is a unilateral declaration by patients, who inform their dentist of all relevant aspects of their health condition. Therefore, it is the patients, or their legal representatives, who must sign it. As for dentists, they must read the questionnaire, inquire about all changes at every visit, and submit it periodically to patients for review, but not sign it. However, there is no reason why you cannot put your signature next to the note.

Consent and identification
I have filled out this medical-dental questionnaire to the best of my knowledge.

The patient must sign the form when filling it out for the first time.

Patient's signature — **16/01/01**
Signature of the patient or designated representative — Date

Patient him/herself ☐
Parent/guardian (if under 14 yrs. old) ☐
Legal/authorized representative ☐
Other ☐

Mr. ☐ Ms. ☐ **Patient's name**
Name in print

I have reviewed the medical-dental questionnaire and indicated all changes.

Signature — Date YY/MM/DD
Signature — Date YY/MM/DD
Signature — Date YY/MM/DD
Signature — Date YY/MM/DD

The patient or his or her legal representative must fill out this section. It is not necessary to ask patients to review the entire questionnaire every time they visit. It is up to you how often you want to have the questionnaire to be fully reviewed. However, you must inquire about all changes in your patients' health at every visit.

Fold here

ASSOCIATION DES CHIRURGIENS DENTISTES DU QUÉBEC

To ensure that the text of the questionnaire is printed right side up, please select "Flip on short edge" in your double-sided printing settings.

Ordre des dentistes du Québec

CONFIDENTIAL MEDICAL-DENTAL QUESTIONNAIRE

A patient's dental file contains information on the care provided to the patient. It is protected by law and professional secrecy and kept at the dental office, where only the dentist and his or her staff have access to it. Patients are also entitled to access their file and make corrections.

Personal Information

First name _____
Last name _____
Sex F ☐ M ☐
Date of birth _____ YY/MM/DD
Health Ins. No. _____ Expiry _____ YY/MM
Address _____
City _____
Province _____ Postal code _____

Contact Information

Home tel. _____
Work tel. _____
Cell phone _____
E-mail _____
For emergencies, call:
Name _____
Relationship to patient _____
Main tel. _____
Cell phone _____

E-mail can be used for communications related to the overall purpose of the file (e.g. confirming an appointment or sending a statement), but not to send electronic messages of a commercial nature (e.g. reminding patients to book a check-up appointment or offering goods and services).

Dental Information

Reason for today's visit _____
Do you fear dental treatments?
Not at all ☐ A little ☐ Very much ☐
Specify _____

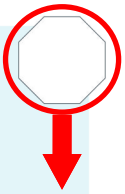
Last visit 0-6 months ☐ 6-12 months ☐ + than 12 months ☐
Treatment(s) received _____ Yes No
With panoramic radiographs (large x-ray) ☐ ☐
With intraoral radiographs (small x-rays) ☐ ☐

This questionnaire will help the dentist and his or her staff provide the best possible care and reduce the risk of medical complications.
It is in the patient's best interest to carefully fill it out and notify the dentist of any change in their health condition.

Patient _____ **Patient's name**

Operative precautions–For use by the professional

In this section, the dentist can enter all precautions required by the patient's health condition. However, the dentist should not forget that the patient has access to the questionnaire.



Pictogram that resembles a stop signal. Can be used as a visual indicator by putting a sticker on it.

Medical history

	Yes	No	Reason, details and date
1. Would you like to speak privately with your dentist?	☐	☐	
2. Are you being treated by a physician?	☐	☐	
3. Have you ever had surgery or been hospitalized?	☐	☐	
4. Do you have joint prostheses (hip, knee, etc.)?	☐	☐	
5. Have you gained or lost a lot of weight recently?	☐	☐	
6. Are you pregnant?	☐	☐	
7. Are you breastfeeding?	☐	☐	
8. Are you taking natural or homeopathic products?	☐	☐	Specify
9. Are you taking medication?	☐	☐	
10. Are you taking birth control ☐ or hormones ☐ ?	☐	☐	

Please indicate all medication (including birth control and hormones) that you are taking or have taken in the last 12 months

Medication and reason	Medication and reason

Please check Yes or No for each current or past condition

	Yes	No
Blood disorders (hemophilia, anemia, prolonged bleeding)	☐	☐
Heart conditions		
Infarction (heart attack), angina, surgery, etc.	☐	☐
Heart infection (endocarditis)	☐	☐
Surgery to replace or repair a valve /cusp	☐	☐
Blood pressure high ☐ low ☐	☐	☐
Dizziness, fainting	☐	☐
Frequent headaches	☐	☐
Jaw pain	☐	☐
Liver disorders (hepatitis A, B, C. cirrhosis, etc.)	☐	☐
Digestive system disorders or diseases	☐	☐
Specify _____		
Stomach disorders ulcer ☐ reflux ☐	☐	☐
Kidney disorders	☐	☐
Diabetes	☐	☐
Thyroid disorders	☐	☐
Cancer (tumour) Specify _____	☐	☐
Radiotherapy	☐	☐
Chemotherapy	☐	☐
Do you suffer from dry mouth?	☐	☐
Sexually transmitted or blood-borne infections (STBBI)	☐	☐
Specify _____		

	Yes	No
Skin diseases	☐	☐
Eye disorders	☐	☐
Earaches	☐	☐
Arthritis	☐	☐
Osteoporosis	☐	☐
Prevention / treatment (e.g.: tablets)	☐	☐
Annual or monthly injection	☐	☐
Chronic pain	☐	☐
Epilepsy	☐	☐
Nervous system disorders or diseases	☐	☐
Mental disorders or illnesses	☐	☐
Frequent colds or sinusitis	☐	☐
Tuberculosis or lung disorders	☐	☐
Asthma	☐	☐
Hay fever / seasonal allergies	☐	☐
Allergy or manifestation with products containing:		
Latex ☐ ☐	Sulfonamides	☐ ☐
Penicillin ☐ ☐	Anesthetic	☐ ☐
Other antibiotics ☐ ☐	Food	☐ ☐
Codeine ☐ ☐	Iodine-containing products	☐ ☐
Aspirin ☐ ☐	Other: _____	☐ ☐
Other medical conditions that should be mentioned: _____		

Other aspects

	Yes	No
Do you snore?	☐	☐
Do you suffer from sleep apnea?	☐	☐
Do you smoke? ____ cig./day or ex-smoker ☐	☐	☐
Do you drink alcohol?	☐	☐
Frequency:____ drinks ☐ /day ☐ /week ☐ /month	☐	☐
Do you take drugs?	☐	☐
Do you take methadone?	☐	☐

Section reserved for the dentist's special notes

In this section, the dentist can enter all precautions required by the patient's health condition. However, the dentist should not forget that the patient has access to the questionnaire.