Cabinet Dentaire
BONNIEUX

MEDICAL QUESTIONNAIRE

This medical questionnaire is designed to avoid interference between oral and dental care treatments or pathologies.
It will integrate your medical record. Your informations are protected by professional secrecy.
So, we please you for fill it form conscientiously, and with your full attention.
Thank you for share with us any changes in health status or medicine treatment since your last visit.

questionnaire

- Last Name : ....
- First Name : ....
- DOB : ....
- Address : ....

....

....

- Country..
- Mobile phone : .. ..
- M@il : ....
- Job : ....

- Do you have medical care in France ?
  ☐ YES ☐ NO

- When was your last dental check-up ?

....

- What is the reason of your visit ?

☐ Pain
☐ Lost crown/bridge
☐ Check-up
☐ Teeth cleaning
☐ Other : ....

- Are you in good health ?
  ☐ YES ☐ NO
- Have you ever admited in a hospital

☐ YES ☐ NO

Why ? ....

When ? ....

- Do you take any medication ?
  ☐ YES ☐ NO

Which ? ....

- Do you have any medicine allergies ?
  ☐ YES ☐ NO

Which ? ....

- Do you smoke ?
  ☐ YES ☐ NO
  How many cigarettes per day ? ....
- Are you pregnant ? ☐ YES ☐ NO
  How many months ? ....
- If you come for a pain, have you taken any painkillers ? ☐ YES ☐ NO

Which one ? ....

- Have you taken any anti-inflammatory or aspirin drugs this week ? ☐ YES ☐ NO

Please turn

questionnaire

➤ Do you use a corticoid treatment ?
☐ YES ☐ NO

➤ Do you have regular gastric ulcers ?
☐ YES ☐ NO

➤ Have you taken any antidepressant therapy this month ?
☐ YES ☐ NO

➤ Are you with anti-platelets agents ?
☐ YES ☐ NO

➤ Have you received/taken an anti-coagulant therapy since this month ?
☐ YES ☐ NO

➤ Have you ever suffered from :
- Diabetes
☐ YES ☐ NO
- Hepatic failure
☐ YES ☐ NO
- Hepatitis B ou C
☐ YES ☐ NO
- Heart attack
☐ YES ☐ NO if yes, when : ....
- Heart failure
☐ YES ☐ NO
- Heart arrhythmia
☐ YES ☐ NO
- Cerebrovascular accident
☐ YES ☐ NO if yes, when : ....
- Pulmonary edema
☐ YES ☐ NO
- Cancer
☐ YES ☐ NO

When ? ....

If yes : ☐ radiation therapy
☐ chemical therapy

- Osteoporosis
☐ YES ☐ NO
- If yes, long-term bisphosphonate therapy
☐ YES ☐ NO
- Stomac or bowel disease
☐ YES ☐ NO
- Kidney failure
☐ YES ☐ NO
- Epilepsy
☐ YES ☐ NO
- Thyroid gland failure
☐ YES ☐ NO
- Asthma
☐ YES ☐ NO
- HIV
☐ YES ☐ NO
- Chronic alcoholism
☐ YES ☐ NO
- Use/addiction of drugs
☐ YES ☐ NO

Wich ? ....

- Degenerative disease like Alzheimer, Parkinson
☐ YES ☐ NO

- Do you hold any transplant/graft ?
☐ YES ☐ NO
- Do you hold any bone prosthesis ?
☐ YES ☐ NO
- Do you have a heart prosthetics valve/transplant ?
☐ YES ☐ NO
- Do you have a low blood pressure ?
☐ YES ☐ NO

➤ Do you have a high blood pressure ?
☐ YES ☐ NO

➤ Have you ever fainted or lost consciousness ?
☐ YES ☐ NO

➤ Have you ever had a local anesthesia ?
☐ YES ☐ NO

➤ If yes, have you ever had an unusual response due to this ?
☐ YES ☐ NO

➤ Have you ever get an important bleeding after a tooth extraction ?
☐ YES ☐ NO

➤ Do you feel anxious / afraid about dental care ?
☐ YES ☐ NO

Thanks for giving back this form to our assistant when it is completed.

Date :

Sign here :