DELISLE DENTAL GROUP

FIRST VISIT QUESTIONNAIRE

* First Name:		* Last Name:	
* DOB:		* Address:	
* City:		* Province:	
* Postal:		* Home Phone:	
* Work Phone:		* Mobile:	
* Email:		* Referred By:	
Physician:		Occupation:	
Employer:		Account Rep.:	
Insurance Co.:		Group #, ID #:	

MEDICAL HISTORY

Please check: Yes No

1. Have you ever had a serious illness or are you under the care of a physician now? ○ ○
2. Have you had a medical examination in the last year? ○ ○
3. Do you use any medicine now? ○ ○
4. Have you ever had any of the following diseases?
   - ○ hepatitis ○ jaundice ○ diabetes ○ high blood pressure
   - ○ tuberculosis ○ any lung disease ○ venereal disease ○ heart attack
   - ○ heart disease ○ stroke ○ epilepsy ○ cancer
   - ○ thyroid disease ○ kidney disease ○ mental/nervous ○ arthritis/rheumatic fever
   - ○ stomach problems ○ allergies ○ HIV/AIDS
5. Do you ever have asthma, hay fever, hives or skin rash? ○ ○
6. Has any member of your family had diabetes? ○ ○
7. Have you ever experienced any unusual reaction to any of the following?
   - ○ aspirin ○ penicillin ○ iodine ○ sulfonamide (sulfa)

○ barbiturates (sleeping pills) ○ local anaesthesia (epinephrine) or other medicine

8. Do you bruise easily or bleed abnormally? ○ ○
9. Do you have any blood disorder such as anaemia (thin blood)? ○ ○
10. Have you ever had any injury, surgery or X-ray therapy to your face or jaws? ○ ○
11. Do you have a tendency to faint? ○ ○
12. Do you have frequent severe headaches? ○ ○
13. Do you have a prosthetic implant? ○ ○
14. WOMEN ONLY – Are you pregnant? (Which month?) ○ ○
15. Do you have any disease, condition or problem not listed above that you think the doctor should know about? ○ ○

If yes, please explain:

DENTAL HISTORY

1. Have you had a regular dental examination (annually) in the past year? ○ ○
2. Do you have any oral habits such as clenching, grinding your teeth or nail biting? ○ ○
3. Have you ever had tooth brushing instruction? ○ ○
4. Have you ever had instruction in using dental floss? ○ ○
5. What concerns you most about your dental health? ○ ○

Date: Signature:

Notes