Cabinet du Sourire

CABINET DENTAIRE DU
DR. MARIE-HÉLÈNE CHRETIEN-FRANCESCINI

GENERAL HEALTH QUESTIONNAIRE

LAST NAME:
FIRST NAME:
DATE OF BIRTH:

The following information is required to enable us to provide you with the best possible dental care.
All information is strictly private, and is protected by doctor-patient confidentiality.
The dentist will review the questions and explain any that you do not understand.
Please fill in the entire form.

	YES	NO	NOT SURE/ MAYBE
1. Are you healthy ?	O	O	O
2. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?	O	O	O
3. Do you smoke ? How many cigarettes / day ?	O	O	O
4. Do you take any prescription drugs ?	O	O	O
If yes, which one(s) :			
5. Have you undergone any major surgery ?	O	O	O
6. Have you been severely ill ?	O	O	O
7. Have you lost a lot of weight recently ?	O	O	O
8. Are you on a diet ?	O	O	O
9. When you hurt yourself, do you take a long time to heal ?	O	O	O
10. Do you have a bleeding problem or bleeding disorder?	O	O	O
11. Have you received treatment for anemia ?	O	O	O
12. Have you ever contracted hepatitis ?	O	O	O
13. Have you ever had radiation therapy ?	O	O	O
14. Have you ever been diagnosed or treated for heart or coronary disease ?	O	O	O
15. Do you suffer from hypertension ?	O	O	O
16. Do you have unexplained fever ?	O	O	O
17. Do you suffer from diabetes ?	O	O	O
18. Does diabetes run in your family ?	O	O	O
19. Do you suffer from any hormonal disorder ?	O	O	O
20. Are you allergic to any drugs ?	O	O	O
If yes, which ones:			
21. Do you suffer from gastritis or stomach ulcers ?	O	O	O
22. Do you suffer from any headaches ? back pains ? neck pains ?	O	O	O
23. Are you getting treatment from a physical therapist (Osteopath) ?	O	O	O
24. If yes, which what frequency ?			

Cabinet du Sourire

WOMEN

CABINET DENTAIRE DU
DR. MARIE-HÉLÈNE CHRETIEN-FRANCESCINI

GENERAL HEALTH QUESTIONNAIRE

NOM:
PRENOM:
DATE DE NAISSANCE:

	OUI	NON	JE NE SAIS PAS
25. Etes-vous suivi par un spécialiste médical ?	O	O	O
26. Avez vous suivi un traitement orthodontique ?	O	O	O
27. En êtes-vous satisfait ?	O	O	O
28. Avez vous des peurs ou appréhensions du traitement dentaire ?	O	O	O
29. Avez vous des troubles gynécologiques ?	O	O	O
30. Prenez-vous la pilule ?	O	O	O
31. Êtes-vous enceinte ?	O	O	O
32. Avez vous des enfants ?	O	O	O
Si oui, quel(s) âge(s) ?			
33. Êtes vous ménopausée ?	O	O	O

Information

Sauf refus explicite de votre part, les photos prises dans le cadre du plan de traitement sont susceptibles d'être utilisées en partie ou en totalité, à des fins d'enseignement, de recherche, culturel ou scientifique, ou d'exploitation commerciale.

PARIS, le **Signature:**