



CABINET DENTAIRE DU
DR. MARIE-HÉLÈNE CHRETIEN-FRANDESCINI

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 ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Do you smoke ? How many cigarettes / day ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Do you take any prescription drugs ? If yes, which one(s) :	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Have you undergone any major surgery ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Have you been severely ill ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Have you lost a lot of weight recently ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Are you on a diet ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. When you hurt yourself, do you take a long time to heal ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Do you have a bleeding problem or bleeding disorder?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Have you received treatment for anemia ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Have you ever contracted hepatitis ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Have you ever had radiation therapy ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Have you ever been diagnosed or treated for heart or coronary disease ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Do you suffer from hypertension ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Do you have unexplained fever ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Do you suffer from diabetes ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Does diabetes run in your family ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Do you suffer from any hormonal disorder ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Are you allergic to any drugs ? If yes, which ones:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Do you suffer from gastritis or stomach ulcers ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. Do you suffer from any headaches ? back pains ? neck pains ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. Are you getting treatment from a physical therapist (Osteopath) ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. If yes, which what frequency ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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	YES	NO	NOT SURE/ MAYBE
25. Are you under treatment from any medical specialist ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Have you followed an orthodontic treatment ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. Are you satisfied with the results ?	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
28. Are you nervous during dental treatment?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

To the best of my knowledge, the above information is correct:

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Signature:

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