AURA
Clinique Dentaire Élite
Dre. Raegan Arnason, DDS.

CONFIDENTIAL QUESTIONNAIRE OF INTRODUCTION

Sex: M___ F___ Last name: ____________________ First name: ____________________

Adress: N°: __________ Street: ____________________ Apt: ______________

City :____________________ Postal Code:____________________

Tel. Res:____________________ Work. :____________________ Cell. : ____________________

Birthdate : Year : _________ Month : _________ Day : _________ E-mail : ____________________

Medicare No: ____________________ Expiry date:____________________

If you are less than 18 years old, indicate name of parent □ or guardian □: ____________________

For an emergency, contact: Full name :____________________ Tel. : ____________________

Reason for visit : ____________________ How did you hear about our clinic? ____________________

MEDICAL HISTORY

Weight : ________ Height : ________

1. Are you presently under a doctor's care? Yes No
If so, reason : ____________________
____
____
____
Full name and tel. of the doctor: ____________________
2. Are you presently taking any drug or medication Yes No
or have you taken any in the last six months : ____________________
____
____
3. Are you presently taking natural or homeopathic products? Yes No
If so, which : ____________________
____
4. Are you presently taking birth control pills or hormones? Yes No
If so, specify :____________________
5. Did you recently experience a significant weight loss or gain? Yes No
6. Are you pregnant or breastfeeding?................................. Yes No

Are you suffering or have you ever suffered from :

7. Heart disease (stroke, angina, prolonged bleeding, etc.)..... Yes No
8. Rheumatic fever .... Yes No
9. Blood problems (hemophilia, anemia, clear blood, etc.)....... Yes No
10. Blood pressure : High □ Low □.. Yes No
11. Frequent colds or sinusitis.. Yes No
12. Tuberculosis or lung problems.. Yes No
13. Digestive problems : Specify : ____________________ Yes No
14. Stomach Ulcer :.. Yes No
15. Liver disease (hepatitis A, B, C, cirrhosis, etc.)................... Yes No
16. Kidney problems.. Yes No
17. Venereal disease (V.D).. Yes No
18. Diabetes.. Yes No
19. Cancer... Yes No
20. Thyroid problems... Yes No
21. Skin disease... Yes No
22. Arthritis.. Yes No
23. Osteoporosis... Yes No
Do you take bisphosphonates? (ex : Fosomax) Yes No

24. Epilepsy.. Yes No
25. Nervous disorders.. Yes No
26. Mental illness.. Yes No
Specify : ____________________
27. Frequent headaches.. Yes No
28. Dizzy spells or fainting spells.. Yes No
29. Asthma.. Yes No
30. Do you smoke?... Yes No
31. Have you ever had radiotherapy or/and chemotherapy..... Yes No
Treatments (tumor)?
32. Do you have AIDS symptoms or AIDS virus?...................... Yes No
33. Do you have artificial joints (knee, hips, etc.)?.................. Yes No
34. Do you snore or have you ever been told that you snore?..... Yes No
35. Do you have any of the following allergies :
Latex..............................Yes No
Iodine.......................... Yes No
Food............................ Yes No
Aspirin........................ Yes No
Sulfonamides.............. Yes No
Penicillin..................... Yes No
Codeine........................ Yes No
Other antibiotics..... Yes No
Local anesthesia......... Yes No
Other, specify : __ ____________________ ____________________
____
36. Do you use drugs?... Yes No
37. Do you drink alcohol?
No/A little □ In moderation □ A lot □
38. Where you ever hospitalized or have you undergone.... Yes No
surgery other than dental? If so, why and when :
____
____
____
39. Do you fear dental treatments?
A little □ A lot □ Not at all □

Signature : ____________________
Date : ____________________