CONFIDENTIAL HEALTH CARE QUESTIONNAIRE

The information on this confidential questionnaire is essential to render the best professional care. We appreciate your cooperation in filling it out carefully, so that we will have accurate records. PLEASE PRINT. THANK YOU.

PATIENT'S LAST NAME	MR. MRS. MISS MS.	GIVEN NAMES	HOME PHONE

ADDRESS	APT	CITY	POSTAL CODE

DATE OF BIRTH DAY MONTH YEAR	AGE	DO YOU HAVE DENTAL INSURANCE? YES ❑ NO ❑

OCCUPATION	EMPLOYER	BUSINESS PHONE

ARE YOU COVERED BY: MOTHER'S ALLOWANCE INDIAN AFFAIRS SOCIAL ASSISTANCE DVA	HEALTH CARD #

NAME OF PERSON RESPONSIBLE FOR PAYING THIS ACCOUNT (IF DIFFERENT FROM ABOVE) ADDRESS:	BUSINESS PHONE

WHO IS YOUR REGULAR DENTIST?	WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?

Please CIRCLE the correct answers. Please GIVE DETAILS of each "YES" answer.

HAVE YOU EVER HAD ANY

- Operations? Serious Illness? NO YES .....
- Rheumatic Fever? NO YES .....
- Seizures? Epilepsy? NO YES .....
- Heart or Blood Pressure Problems? NO YES .....
- Heart Murmur? NO YES .....
- Lung or Breathing Problems? NO YES .....
- Hepatitis? NO YES .....
- Liver or Kidney Problems? NO YES .....
- Diabetes? NO YES .....
- Thyroid or any other Hormonal Problems? NO YES .....
- Stomach or Intestinal Problems? NO YES .....
- Tendency to bleed a lot? Anemia? NO YES .....
- Hayfever? Asthma? NO YES .....
- Any other Allergies? NO YES .....
- Reaction or allergy to: Penicillin? NO YES .....
  Codeine? NO YES .....
  Other Drugs? NO YES .....
- Have you ever had any problem with local anaesthetic ("freezing") ? NO YES .....
- Do you smoke? NO YES .....
- Do you have a history of alcohol or drug abuse? NO YES .....
- Have you ever been tested for the AIDS Virus? NO YES .....
  If yes, are you positive or negative? .....
- Have you or any member of your family ever had a problem with nitrous oxide (gas) or a general anaesthetic NO YES .....
- Do you have Obstructive Sleep Apnea? NO YES .....

Aside from your regular checkups are you now under treatment by a physician? NO YES .....

What pills or medicines are you taking now: .....

Is there anything else concerning your health that the doctor should know about? NO YES .....

Approximately when did you have your last physical examination? .....

What is your Family Physician's name: .....

Women: Are you pregnant now? NO YES In Your ..... Month

TODAY'S DATE

SIGNATURE