Centre Dentaire Rafik Boulos

Last Name	First Name	Language	Sex	Age
		Français: _____ English: _____	M / F	

Date of Birth (AAAA-MM-JJ)	Medicare Number	Dental Insurance

Phone Number (Home)	Phone Number (Cell)	Phone Number (Work)

Address	Appt#	Postal Code	City

Email, PLEASE PRINT LETTERS	Guardian
	Father / Mother/ Tutor/Other Name:_____ Telephone: _____

Occupation	I have been refered by (Family member, friend/collegue, internet,...)

MEDICAL HISTORY

Do you suffer from, or have you ever suffered from:

	YES	NO
Heart disease (stroke, angina, valvular problems, murmur,...)		
High ☐ Low ☐ blood pressure		
Renal Problems		
Anemia		
Prolonged bleeding		
Thyroid problems		
Diabetes		
Epilepsy		
Arthritis		
Earaches		
Frequent headaches		
Nervous disorders		
Dizzy spells and fainting spells		
Digestive problems		
Stomach ulcers		
Liver disease (Hepatits A, B, C, cirrhosis)		
Venereal disease		
Tuberculosis or lung problems		
Hay fever		
Frequent colds or sinusitis		
Asthma		
Do you suffer from sleep apnea?		
Are you HIV positive?		
Do you have artificial joints (knee, hip,..)		

		YES	NO
Have you ever undergone radiotherapy or/and chemotherapy treatments?			
Do you smoke If so, since when and how often?			
Are you or could you be pregnant?			
Are you presently under a doctor's care? Name: Number:			
Were you ever hospitalized or have you undergone surgery ? If so, indicate which ones and when?			
Are you presently taking any drug or medication, or have you taken any in the last six months? If so, please list them:			
Are you allergic to any of the following:	- Food		
	- Penicillin		
	- Aspirin		
	- Iodine		
	- Sulfonamides		
	- Codeine		
	- Local anesthesia		

NOTES

I, the undersigned, hereby declare that I have read, understood, and answered the above medical questionnaire to the best of my knowledge. I also hereby promise to inform you of any change to my health.

Patient's Signature	Attending Dentist's Signature	Date