ORTHODONTISTES
DI BATTISTA
ROUSSEAU

MEDICAL AND DENTAL QUESTIONNAIRE

Patient's last name: _____First name: _____Sex: F__ M__
Address: No: _____Street: _____App: _____City:_____ Postal Code: _____
Tel. Res: (____) _____ Office: (____)_____Ext :_____ Cellular_____
Age: _____ Date of birth: Day _____ Month _____ Year _____ Height: _____Weight _____
E-Mail address:_____
Mother's Name _____Office tel: _____Cell:_____
Father's Name _____Office tel: _____Cell:_____
Address (if different): No _____Street: _____App:_____ City: _____ Postal Code: _____
Are you the person responsible for the payment? Yes ____ No: ____
If not, name of the person responsible_____ Relationship with the patient: _____

Do you carry a dental insurance plan? Yes_____ No _____
Name of the person who referred you to us Dentist _____ Friend _____Publicity_____
Name of your dentist: _____

MEDICAL HISTORY
Are you suffering or have you ever suffered from?

Arthritis	Yes___ No___	Earaches	Yes ___No ___
Anemia	Yes___ No___	Fainting spells	Yes ___No ___
Asthma	Yes___ No___	Rheumatic fever	Yes___ No____
Tuberculosis	Yes___ No___	Heart disease	Yes ___No ___
Diabetes	Yes___ No___	High or low blood pressure	Yes ___No___
Epilepsy	Yes___ No___	Kidney or liver disease	Yes ___No ___
Nervous disorders	Yes___ No___	Thyroid problem	Yes ___No___
Dizziness	Yes___ No___	Radiation treatment (cancer)	Yes ___No ___

Are you presently under a doctor's care? Yes____ No _____
If yes, for what reason? _____Name of your physician: _____
Are you taking any medication or have you taken any in the last 6 months? Yes ____No _____
If so, which? _____
Do you bleed abnormally when you are injured? Yes ____ No _____
Do you have frequent colds? Yes ____ No _____

Are your tonsils or / and adenoids removed? _____ If yes, when? _____

Are you **ALLERGIC** or have you ever experienced **discomfort** when taking certain **medication or food? Yes _____No ____**
If so, which: _____
_____
Please let us know any further information regarding your medical history:
_____
_____

DENTAL HISTORY
Date of your last dentist's examination: _____
How many times a year do you visit your dentist? _____
How many times a day do you brush your teeth? _____

Have you had any accident to your face?	Yes _____No ____
Have you had any injuries to your head or maxillaries in mouth?	Yes _____No ____
Did you ever had an orthodontic treatment?	Yes _____No ____
Do you hear any cracking noises in your jaw joints?	Yes _____No ____
Did you ever suck your thumb?	Yes _____No ____
Do you still suck your thumb?	Yes _____No ____
Does the esthetic appearance of your teeth bothers you and do you wish to correct it?	Yes _____No_____
Have you ever seen a speech therapist?	Yes _____No_____
Does any other member of the family had an orthodontic treatment?	Yes _____No ____
If yes, indicate the name of the professional who did the correction	_____

☐ Dr. Luigi Di Battista

☐ Dr. Martin Rousseau

_____ _____
Patient's signature (or parent if minor) Date