FHDQ

Fédération des hygiénistes dentaires du Québec

PERSONAL AND CONFIDENTIAL INFORMATION

LAST NAME: _____ FIRST NAME: _____ SEX : F ☐ M ☐ Other ☐

BIRTH DATE: Year: _____ Month: _____ Day: _____ GUARDIAN: _____

ADDRESS: No: _____ Street: _____ Apt.: _____ City: _____ Postal Code: _____

PHONE. : Home: _____ Cell: _____ Email: _____

IN CASE OF EMERGENCY, contact: _____ Tel.: _____

No RAMQ: _____ Exp. :Month: _____ Year: _____

REASON OF VISIT: _____

DISABILITIES AND LIMITATIONS: Wheelchair ☐ Cane ☐ Medical Walker ☐ The patient must be accompanied ☐

Details: _____

Antibiotic Prophylaxis Required: YES ☐ NO ☐

MEDICAL HISTORY

	YES	NO
1. Are you currently under the care of a doctor?	☐	☐
If Yes		
Last name: _____ First name: _____		
Specialty: _____		
Frequency of follow-ups: _____ Reason: _____		
2. Are you taking or have you taken in the last 6 months any medicines, natural or homeopathic products?	☐	☐
If so, complete the "Drug History" table on the back		
3. Have you had a fever over 38 ° C in the past week?	☐	☐
4. Have you been hospitalized in the past 2 years?	☐	☐
If Yes		
Reason: _____ Year: _____		
Reason: _____ Year: _____		
Reason: _____ Year: _____		
5. Do you use tobacco, drugs, alcohol?	☐	☐
6. During the past 6 months, have you had:		
☐ Acupuncture ☐ Permanent makeup		
☐ Electrolysis ☐ Body piercing		
☐ Injury with a contaminated needle		
7. Are you pregnant?	☐	☐
If so, how many weeks _____		
Are you taking birth control medications?	☐	☐
Are you postmenopausal?	☐	☐
8. Have you ever had an allergic reaction to the following products:		
Latex	☐	☐
Aspirin	☐	☐
Penicillin	☐	☐
Food	☐	☐
Others	☐	☐
Do you suffer or have you suffered from:		
9. Cardiac disorders (infarction, angina, arrhythmia, heart murmur endocarditis, valve disease)	☐	☐
10. Blood pressure disorders (high or low)	☐	☐
11. Vascular disorders (stroke, thrombophlebitis)	☐	☐
12. Blood disorders (hemophilia, anemia, mononucleosis)	☐	☐
13. Lung disorders (asthma, emphysema, tuberculosis, COPD)	☐	☐
14. Liver problems (jaundice, hepatitis A B C, cirrhosis)	☐	☐
15. Digestive disorders (reflux, stomach ulcer, Crohn's disease)	☐	☐
16. Endocrine disorders (hypothyroidism, hyperthyroidism)	☐	☐
17. Kidney problems (failure, kidney stones)	☐	☐
18. Neurological disorders (epilepsy, Parkinson's, multiple sclerosis)	☐	☐
19. Cognitive and learning disorders (ADD, ADHD, autism, PDD)	☐	☐
20. Psychiatric disorders (depression, anxiety, schizophrenia, bipolar personality disorder, borderline personality disorder)	☐	☐
21. Inflammatory diseases (arthritis)	☐	☐
22. Infections transmissible through blood and saliva (STBBI / STD)	☐	☐
23. Rheumatic fever	☐	☐
24. Diabetes (Type I or II)	☐	☐
25. Sinusitis, chronic rhinitis	☐	☐
26. Glaucoma	☐	☐
27. Cancer	☐	☐
If Yes		
Localization: _____ Year: _____		
Treatments: _____		
28. Have you had a transplant?	☐	☐
29. Do you have one or more joint prostheses? (hip, knee)	☐	☐
If so, for how many days? _____		
30. Do you follow a special diet?	☐	☐
31. Do you have acute immunodeficiency syndrome (AIDS)?	☐	☐
32. Are you HIV positive?	☐	☐
33. Frequent headaches, migraines	☐	☐
34. Loss of consciousness, dizziness	☐	☐
35. Abnormal weight loss or gain, anorexia, difficulty swallowing	☐	☐
36. Fatigue or significant stress	☐	☐

This form is designed and distributed by the Fédération des hygiénistes dentaires du Québec

I, the undersigned, declare that I have read, understood, have informed myself and answered the medical questionnaire to the best of my knowledge. I hereby agree to notify you of any changes in my health. I hereby authorize the constitution of my dental hygiene file. I have been informed that my file will be kept at the attending dental hygienist's office at all times and be accessible only to the dental hygienist team. The information contained within is protected by law and professional secrecy. I have been informed of my right to consult my file at all times and can request a correction if necessary.

Signature of patient / Responsible: X _____ Date: _____

I acknowledge that I have read the answers entered in the medical questionnaire and have taken the necessary precautions, if necessary.

Signature of dental hygienist: X _____ Date: _____

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MEDICATION

NAME	Mg / day	CONDITION	CLASSIFICATION	DATE	COMMENTS

COMPLEMENTARY NOTES

EFFACER LE FORMULAIRE