FHDQ
Fédération des hygiénistes dentaires du Québec

PERSONAL AND CONFIDENTIAL INFORMATION

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

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. : Day: _____ Month: _____ Year: _____

REASON OF VISIT: _____

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

Physical disability: _____

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 for 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:		
☐ Tattoo ☐ Acupuncture		
☐ Permanent makeup ☐ Electrolysis		
☐ Body piercing ☐ Injury with a contaminated needle		
7. Women:		
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:	YES	NO
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 (HAT, 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	☐	☐

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 all times at the attending dental hygienist's office and accessible only to the dental hygienist team. I have also been informed of my right to consult my file at all times and 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: _____

EFFACER LE FORMULAIRE

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MEDICATION

NAME	Mg / day	CONDITION	CLASSIFICATION	DATE	COMMENTS

COMPLEMENTARY NOTES

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