Medical and Dental Questionnaire

The following information is essential to insure you of the best treatment possible.
Please answer all the questions. This document will be kept strictly confidential.

DR OLIVIER QUINTIN ORTHODONTISTE

General Information

Patient's last name: _____ First name: _____ Gender ☐ M ☐ F

Age: _____ Date of birth: Day _____ Month _____ Year _____ Weight: _____ Height: _____

Occupation: _____ School: _____ Grade: _____

Address: No. _____ Street _____ Apt ____ City: _____ Postal code: _____

Phone: Home: _____ Work: _____ Mobile: _____

Person in charge of payments: _____ Relationship with patient: _____

E-mail address of person in charge: _____

Do you have an insurance plan with orthodontic coverage? ☐ Yes ☐ No

You have been referred to our office by: _____

Reason for consultation: _____

Dental History

Name and address of your current dentist: _____

Frequency of exams at the dentist: _____

Have you ever consulted in orthodontics? ☐ Yes, when? _____ ☐ No

Have you ever had orthodontic treatment? ☐ Yes, when? _____ ☐ No

Oral Habits

Thumb (finger) sucking ☐	Lip or cheek biting ☐
Nail biting ☐	Frequent gum chewing ☐
Mouth breathing ☐	Jaw clenching (day/night) ☐
Tongue thrusting ☐	Tooth grinding (day/night) ☐
Other ☐ _____	

	Yes	No
Have you ever had an injury to your head/face?	☐	☐
Have you ever had a dental trauma (blow to the teeth, tooth fracture, etc.)?	☐	☐
Have you ever had surgery to the head, the face, the jaws or in the mouth?	☐	☐
Do you have trouble opening your mouth?	☐	☐
Do your jaw joints crack or make noises?	☐	☐
Do your gums bleed?	☐	☐

Medical History

Name and address of your physician:

_____

Date of your last medical exam: _____

Are you presently under the care of a physician? ☐ Yes ☐ No

If so, for what reason? _____

Have you ever been **hospitalized**? ☐ Yes ☐ No

If so, for what reason? _____

_____

Do you smoke? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Do you take any **medication** or natural products, or have you taken any in the last 6 months? ☐ Yes (please write which ones) ☐ No

_____

Do you take birth control pills? ☐ Yes ☐ No

Have you ever had an **allergic reaction** to any food, medication or other substance? ☐ Yes (please write which ones) ☐ No

☐ Penicillin ☐ Other medication : _____

☐ Other : _____

Have you ever seen an ENT specialist? ☐ Yes, when? _____ ☐ No

Do you snore or suffer from sleep apnea? ☐ Yes ☐ No

Have you had your tonsils and/or your adenoids removed?

☐ Yes : Age at time of surgery : _____ ☐ No

Have you ever seen a speech therapist? ☐ Yes ☐ No

If so, for what reason? _____

Growth : Teenage girls: Age at which you had your first period: ____

Teenage boys: Age at which your voice started to change: ____

Do you suffer or have you ever suffered from:	Yes	No
Heart problems	☐	☐
Blood pressure problems..... ☐ high ☐ low	☐	☐
Rheumatic fever or endocarditis	☐	☐
Prolonged bleeding	☐	☐
Anemia	☐	☐
Tuberculosis or lung problems	☐	☐
Asthma	☐	☐
Hay fever or allergies to dust or animals	☐	☐
Frequent colds or sinusitis	☐	☐
Persistent cough	☐	☐
Earaches	☐	☐
Digestive problems	☐	☐
Liver problems (hepatitis, cirrhosis, etc.)	☐	☐
Kidney problems	☐	☐
Diabetes	☐	☐
Problems with thyroid or other glands	☐	☐
Skin problems	☐	☐
Eye problems (glaucoma, etc.)	☐	☐
Arthritis	☐	☐
Epilepsy	☐	☐
Frequent headaches	☐	☐
Dizziness, fainting	☐	☐
Psychological or emotional disorder	☐	☐
Sexually transmitted infection	☐	☐
HIV virus carrier (HIV positive)	☐	☐
Radiation therapy for tumor or other reasons	☐	☐

Other pertinent medical or dental information: _____

I hereby declare that I have understood and answered this questionnaire to the best of my knowledge.

Signature: _____ Date: _____ Signature Dr. Quintin: _____

Name of parent or guardian (please print): _____