Dr. Manuela Barsan
dental surgeon / chirurgienne dentiste

Medical History

questionnaire is confidential

100A-1 Place du Commerce,Nun's Island, QC
Phone: **(514) 768-2587**
info@drbarsan.com • www.drbarsan.com

Patient Name	**Medical Alert** *(Office Use Only)*

Address _____ City _____ Postal Code _____

Phone (home) _____ (cell) _____ Sex M ☐ F ☐ Age _____ Birth Date ____ / ____ / ____
(month / day / year)

Adult Patient

Phone (work) _____
Email _____

Child Patient

Mother's Name _____ Phone (work) _____
Father's Name _____ Phone (work) _____
Person responsible for account _____

Dental Insurance No ☐ Yes ☐ _____

How did you find our office? Friend ☐ Friend's Name _____ Newspaper ☐
Flyer ☐ Internet ☐ Website _____ Other ☐ Please Specify _____

1. Have you been under the care of a medical doctor during the past two years? Yes ☐ No ☐
If yes, for what? _____
Physician's name _____ Phone _____

2. Have you taken any medication or drugs during the past two years? Yes ☐ No ☐

3. Are you taking any medication, drugs or pills now? Yes ☐ No ☐
If yes, please list the name and dosage _____

4. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes ☐ No ☐
If yes, please list _____

5. Have you been a hospitalized in the past five years? Yes ☐ No ☐

6. Indicate which of the following you have had, or presently have

Heart (Surgery, Disease, Attack)	Yes ☐ No ☐	Latex Sensitivity	Yes ☐ No ☐	Hepatitis (A,B or C)	Yes ☐ No ☐
Chest Pain	Yes ☐ No ☐	Stomach Ulcers	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐
Congenital Heart Disease	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Jaundice	Yes ☐ No ☐
Heart Murmur	Yes ☐ No ☐	Thyroid Problems	Yes ☐ No ☐	Venereal Disease / Sexually Transmitted Diseases	Yes ☐ No ☐
High Blood Pressure	Yes ☐ No ☐	Eye problems	Yes ☐ No ☐	A.I.D.S.	Yes ☐ No ☐
Artificial Heart Valve	Yes ☐ No ☐	Emphysema	Yes ☐ No ☐	H.I.V. Positive	Yes ☐ No ☐
Mitral Valve Prolapse	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐	Cold Sores / Fever Blisters	Yes ☐ No ☐
Pacemaker	Yes ☐ No ☐	Asthma	Yes ☐ No ☐	Blood Transfusion	Yes ☐ No ☐
Rheumatic Fever	Yes ☐ No ☐	Hay Fever	Yes ☐ No ☐	Hemophilia	Yes ☐ No ☐
Arthritis / Rheumatism	Yes ☐ No ☐	Allergies	Yes ☐ No ☐	Bruise Easily / Prolonged Bleeding	Yes ☐ No ☐
Stroke	Yes ☐ No ☐	Sinus Trouble	Yes ☐ No ☐	Neurological Disorders	Yes ☐ No ☐
Diet (Special / Restricted)	Yes ☐ No ☐	Radiation Therapy	Yes ☐ No ☐	Epilepsy or Seizures	Yes ☐ No ☐
Artificial Joints (hip, knee etc.)	Yes ☐ No ☐	Chemotherapy	Yes ☐ No ☐	Fainting or Dizzy Spells	Yes ☐ No ☐
Kidney Trouble	Yes ☐ No ☐	Tumors	Yes ☐ No ☐	Frequent Headaches	Yes ☐ No ☐
				Do You Smoke	Yes ☐ No ☐

7. Do you have, or have you had any disease, or problem not listed? Yes ☐ No ☐
If yes, please list _____

8. Women Are you: **Pregnant?** Yes ____ Months No ☐ **Nursing?** Yes ☐ No ☐ **Taking Birth Control Pills** Yes ☐ No ☐

I, the undersigned, hereby declare that I have read, understood and answered the above questionnaire to the best of my knowledge. I also hereby promise to inform you of any change to my health.
I authorize the setting up of my dental file, its follow-up as well as my registration on the recall list of the attending dentist.

Patient / Guardian Signature _____ Date 76 / ____ / ____
(month / day / year)

Save Print Email