Name : .... First name : .... Date of birth : ..../......../........

Profession : ....

MEDICAL HISTORY - QUESTIONS

Have you had any change in your health this past year ? ☐yes ☐no

Have you been hospitalised in the last five years ? ☐yes ☐no

Who is your general practioner if needed ? ………………………….........

HEALTH PROBLEMS OR DISEASE HISTORY

Check present or past diseases :

☐Anemia
☐ Depression
☐ Anxiety
☐ Cardiopathy or heart deasease
☐ Asthma
☐ Ear problems
☐ Prothesis - other than dental
☐ Hormonal disorders
☐ Epilepsy or convulsion
☐ Stomac ulcers
☐ Tuberculosis
☐ Viral hepatitis A, B or C
☐ Tetany
☐ HIV
☐ Blood disorders
☐ Kidney disorders
☐ Heart murmur or heart valve dysfunction
☐ Other : ……………………….....................
☐Glaucoma
☐ Haemophilia
☐ Diabetes
☐ Fainting
☐ Thyroid problems
☐ Osteoporosis

OTHER

Have you ever had unusual bleeding during a surgical operation,
a tooth extraction or an accident ?☐ Yes ☐ No

Do you smoke ? ☐Yes ☐ No If yes, how many cigarettes a day ? ….........

MEDICAL TREATMENTS

Have you been treated with biphosphonates ? ☐ Yes ☐ No

☐ Zométa ☐ Arédia ☐ Brondanate ☐ Fosavance ☐ Bonviva ☐ Didronel ☐ Actonel ☐ Clastaban
☐ Sutent ☐Avastin ☐ Steovess ☐ Denosumab ☐ Lytos

Are you curently under one or any of these treatment (s)?

☐ Antibiotic
☐ Aspirin
☐Cortisone
☐ Blood presure treatment
☐Tranquilizers
☐ Other : ……………………………………………………………………………
☐Anthistamine
☐Insulin

ALLERGY

Have you ever had serious allergical reactions ? ☐yes ☐ no

Are you allergic to one or any of these following products ? (Check the answer)

☐ Dental local anesthetics
☐ Antibiotics
☐ Iodine or iodized products
☐ Neuroleptic or sleeping pills
☐ Metal
☐ Anti-inflamatory or aspirin
☐ Latex
☐ Codeine
☐ Barbiturics

☐ Others ?...

Do you have any other diseases or problems to be aware of to provide care under best conditions ?
If yes, what are they : ……………………………………………..

FOLLOWING QUESTIONS FOR WOMEN ONLY

Are you pregnant ? ☐ No ☐yes, how many months : ….....

How many times have been pregnant ? ………. times.

Do you use the contraceptive pill ? ☐ No ☐Yes

Are you menauposed ? ☐ No ☐Yes

What is the reason for your visit ? Why are you consulting ?...

Complete next page please

GUMS

	YES	NO
Do you feel you have bad breath ?	☐	☐
Has one of your teeth moved or feels mobile ?	☐	☐
Do your gums bleed after brushing, or spontaneously ? If yes how many time a week ?	☐ …...	☐
Are your gums painful or sensitive ?	☐	☐
Does the calculus or tartar appear quickly on your teeth ?	☐	☐
Have some people in your family suffered of bone recession/ bone loss or lost some of their teeth ?	☐	☐

	YES	NO
If you have missing teeth that have been extracted, have they been replaced ?	☐	☐

If yes by : O a bridge O a denture O an implant
If no, for what reason ? ……………………………………………………………………………….…

Do you have any burning sensations in the mouth ?	☐	☐
Do you feel that spaces between your teeth have become bigger ?	☐	☐
Do you get a lot of food trapping ?	☐	☐

MAXILLARIES

	YES	NO
Do you often have head, neck or ear pain ?	☐	☐
Do you have problems opening your mouth wide ?	☐	☐
Do your jaws crack when you open your mouth ?	☐	☐
Do you clench or grind your teeth ?	☐	☐

DENTAL HYGIENE

What kind of tooth brush do you use : HARD ☐ MEDIUM ☐ SOFT ☐

	YES	NO
Do you use floss or inter proximal brushes ?	☐	☐

When was your last cavity treated? : ……/……/……

ESTHETICS

	YES	NO
When you smile do you feel your teeth have the same color ?	☐	☐
Would you like to have whiter teeth ?	☐	☐
Are you satisfied with the look of your teeth and gums ?	☐	☐

If you could change your smile, what would you like to change ? …………………………………….......

OTHER

	YES	NO
Do you want to be called for recall visits ?	☐	☐
Did you have any particular problem in previous dental treatments ?	☐	☐

If yes, what are they ? ……………………………………………………………………….…
What is your main concern regarding your teeth ? ………………………………………………………
Do you have a mutual insurance or complementary insurance ? …………………………………...
What are the day and the hours you prefer for appointments ? ………………………..………...

I certify the information on this document is exact. I will immediatly inform any changes concerning my health and any medical presciptions.

Aix en Provence Date : Signature