PATIENT QUESTIONNAIRE

Welcome to our Practice

Please answer these questions as completely as possible
It will greatly assist us to provide the best dental treatment for you.

Australian Dental Association (WA Branch) Inc

Name(Mr/Mrs/Miss/Ms/Dr/Other)..... (First names) (Family name)

Address .....

..... Postcode .....

Date of Birth ..... Phone (Home) ..... Phone (Work) .....

Phone (Mobile) ..... Preferred Daytime Contact: Home / Work / Mobile
(Please Circle)

E-mail.....

Occupation ..... Employer .....

Person responsible for payment of this account .....

Whom may we thank for recommending you to our practice? .....

Which Health Fund do you belong to? .....

MEDICAL QUESTIONNAIRE - PRIVATE & CONFIDENTIAL

The state of your health may have a very significant effect on your dental care.
Please answer these questions fully or discuss them with your dentist:

	Y	N
• I have private and confidential medical matters which I wish to discuss with the dentist	☐	☐
• Are you receiving any medical treatment at present?	☐	☐
• Name of your medical practitioner / specialist		
• Have you ever been in hospital?	☐	☐

- Some medicines may interfere with your dental treatment or react with medicaments used by your dentist. It is important that your dentist knows precisely what medications (if any) that you are taking.

  Please provide details (***<u>including dose and frequency</u>***) of any medicine or medication that you are currently taking, or have been taking recently. This should include:

  - ☐ Aspirin .....
  - ☐ Oral contraceptive .....
  - ☐ Hormone Replacement Therapy .....
  - ☐ Cortisone or steroids .....
  - ☐ Warfarin or Heparin or other blood thinning medicine .....
  - ☐ Medication for depression (MAOIs or tricyclics) .....
  - ☐ Treatment for osteoporosis (Bisphosphonates) .....
  - ☐ Any herbal or naturopathic medications .....
    .....
  - ☐ Any 'over the counter' medications .....
    .....
    .....

If you are in any doubt about your medication, please bring the bottle or packet(s) to the practice to show the dentist.

..... please turn over ➔

Please indicate YES or NO if you have <u>ever</u> had any of the following:

	Y	N		Y	N
Rheumatic Fever	☐	☐	Thyroid disease (Including goitre)	☐	☐
Any heart (cardiac) complaint / treatment	☐	☐	Tuberculosis (TB)	☐	☐
Cardiac pacemaker	☐	☐	Asthma/bronchitis/lung conditions	☐	☐
Heart valve replacement	☐	☐	Any nervous system disorder	☐	☐
High or low blood pressure	☐	☐	Gastroesophageal reflux disease (GORD)	☐	☐
Anti-coagulant (blood thinning)	☐	☐	Radiation therapy	☐	☐
Blood disorders	☐	☐	Allergy or reaction to any medicine (including Penicillin or other antibiotic)	☐	☐
Excessive bruising or bleeding	☐	☐			
Osteoporosis or low bone density	☐	☐	Allergy to any foods,chemical or substance (such as chlorine, latex, antiseptics)	☐	☐
Diabetes or family history of diabetes	☐	☐			
Hepatitis, jaundice or liver disease	☐	☐	Transplanted organ or bone marrow	☐	☐
Joint replacement surgery	☐	☐	Treatment for any form of cancer	☐	☐
Neck/Jaw or Shoulder damage or pain	☐	☐	X-rays	☐	☐
Epilepsy (Fits)	☐	☐			

Do you smoke? Y ☐ N ☐ What do you smoke? (cigarettes/cigars/pipe/other) .....

If yes, for how long? ..... How much do you smoke ..... per day

Have you ever required any treatment for smoking related diseases or conditions? Y ☐ N ☐

Do you suffer from any illness not listed above or carry any infectious disease? Y ☐ N ☐

If yes, please provide details .....

.....

FEMALES: Are you pregnant? Y ☐ N ☐ If yes, when are you due? .....

Are you breastfeeding? Y ☐ N ☐

DECLARATION:

In signing this form I acknowledge that this represents an accurate medical history.
I will advise my dentist of any changes to my medical history in the future.
I understand that all medical details will be treated with complete professional confidentiality.
I have read the privacy document provided by this practice.

Patient Signature ..... Date .....

(Parent or guardian if under 18 years)

Information Reviewed:

Patient Signature: ..... Date: .....

Dentist Comment: .....

..... Date: .....

Patient Signature: ..... Date: .....

Dentist Comment: .....

..... Date: .....

Patient Signature: ..... Date: .....

Dentist Comment: .....

..... Date: .....