

PATIENT QUESTIONNAIRE



Australian Dental
Association
(WA Branch) Inc

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.

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 |
|---|--------------------------|--------------------------|
| <input type="checkbox"/> I have private and confidential medical matters which I wish to discuss with the dentist | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Are you receiving any medical treatment at present? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Name of your medical practitioner / specialist | | |
| <input type="checkbox"/> Have you ever been in hospital? | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> 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 (**including dose and frequency**) 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 ever had any of the following:

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

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: