PATIENT PERSONAL & MEDICAL QUESTIONNAIRE

PRIVATE & CONFIDENTIAL

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 ……

Emergency Contact ..... Relationship ..... Phone .....

Person responsible for payment of accounts .....

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

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

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? If yes, nature of hospitalisation and dates:	☐	☐

- 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 .....
  - ☐ Warfarin or Heparin or other blood thinning medicine .....
  - ☐ Oral contraceptive .....
  - ☐ Hormone Replacement Therapy .....
  - ☐ Cortisone or steroids .....
  - ☐ Medication for depression (MAOIs, SSRIs or Tricyclics) .....
  - ☐ Treatment for osteoporosis (Bisphosphonates, Prolia) .....
  - ☐ Any other prescription medication ....
  - ☐ 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	☐	☐	Anxiety/Depression	☐	☐
Anti-coagulant (blood thinning)	☐	☐	Gastroesophageal reflux disease (GORD)	☐	☐
Blood disorders	☐	☐	Inflammatory Bowel disease	☐	☐
Excessive bruising or bleeding	☐	☐	Chemotherapy/Radiation therapy	☐	☐
Osteoporosis or low bone density	☐	☐	Treatment for cancer (type/region)	☐	☐
Diabetes or family history of diabetes	☐	☐	Allergy or reaction to any medicine (including		
Hepatitis, jaundice or liver disease	☐	☐	Penicillin or other antibiotic)	☐	☐
Urinary tract/Kidney disease	☐	☐	Allergy to any foods,chemical or substance		
Joint replacement surgery	☐	☐	(such as chlorine/latex/antiseptics/elastoplast)	☐	☐
Neck/Jaw or Shoulder damage or pain	☐	☐	Transplanted organ/bone marrow/stem cells	☐	☐
Epilepsy (Fits)	☐	☐	Snoring/Sleep Apnoea	☐	☐

Have you ever smoked? Y ☐ N ☐ Approx date if Quit ...../...../..... Do you currently smoke? Y ☐ N ☐

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

Have you ever used illicit substances Y ☐ N ☐ .....

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)

Dentist Signature ..... Date .....

Practice Use Only: Review of Information

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

Dentist Comment: .....

..... Signature ..... Date: ...../...../.....

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

Dentist Comment: .....

..... Signature ..... Date: ...../...../.....

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

Dentist Comment: .....

..... Signature ..... Date: ...../...../.....