

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.

PRIVACY STATEMENT: We value your privacy. All of the information which you provide to us will be held and used by us in accordance with our Privacy Policy. A copy of our Privacy Policy is attached to this Questionnaire. Please take the time to read through our Privacy Policy before answering the Questionnaire and speak to one of our staff members if you have any concerns about how we will use your personal information.

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

Private Health Fund (if applicable)

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 | <input type="checkbox"/> | <input type="checkbox"/> |
| • Are you receiving any medical treatment at present? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Name of your medical practitioner/specialist | | |
| • Have you ever been in hospital? If yes, nature of hospitalisation and dates:
..... | <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 list any medications you are currently taking, or have been taking recently **including** herbal remedies, vitamins, supplements, cold/flu treatments, sleeping pills, pain relievers, injections, implants, so we can take appropriate precautions and avoid drug interactions.

Drug Name	Dosage	Duration of Treatment	Purpose/Condition

Please list any known **ALLERGIES** or **ADVERSE REACTIONS** to drugs (especially antibiotics eg. penicillin), medicines, antiseptics, local anaesthetics, preservatives that we should know about.

Drug Name	Nature of Reaction	How Long Ago

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

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"/>
Heart condition/cardiac surgery/pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve replacement	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Bronchitis/lung conditions.....	<input type="checkbox"/>	<input type="checkbox"/>
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Nervous system disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bruising or bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Gastroesophageal reflux disease (GORD).....	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, jaundice or liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Treatment for cancer (type/region).....		
Kidney/renal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes or family history of diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy/Radiation therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis or low bone density	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to any foods, chemical or substance		
Rheumatoid arthritis/Lupus (SLE)/Polymyalgia ..	<input type="checkbox"/>	<input type="checkbox"/>	(eg. chlorine/latex/elastoplast).....	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement surgery	<input type="checkbox"/>	<input type="checkbox"/>	Transplanted organ/bone marrow/stem cells	<input type="checkbox"/>	<input type="checkbox"/>
Jaw, neck or shoulder injury or pain	<input type="checkbox"/>	<input type="checkbox"/>	Snoring/Sleep Apnoea	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>			

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 and/or recreational drugs? Y N If yes, when? Recent More than 1 yr ago

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 or is there a chance you could be pregnant? Y N If yes, date due

Are you currently 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: /..... /.....