

PATIENT PERSONAL & MEDICAL QUESTIONNAIRE

PRIVATE & CONFIDENTIAL



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.

I have read and agree with the terms of the Privacy Policy. Signature:.....

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?

EMAIL ANNOUNCEMENTS

I would like to receive Western Smiles announcements via email. This may include, our newsletter, general information, offers, promotions, etc...

Signature:.....

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 Y N
- Are you receiving any medical treatment at present? Y N
- Name of your medical practitioner / specialist
- Have you ever been in hospital? If yes, nature of hospitalisation and dates: Y N

- 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.

- Are you taking any of the following medications?
 - Aspirin Cortisone or Steroids
 - Warfarin, Heparin or other blood thinning medicine Medication for depression (MAOIs, SSRIs or Tricyclics)

- Oral Contraceptive
- Treatment for osteoporosis (Bisphosphonates, Prolia)
- Any other prescription medications
- Any Herbal or naturopathic medications
- Any "over the counter" medications

Hormone Replacement Therapy

If you are in any doubt about your medication, please bring 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"/>
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"/>	Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anti-coagulant (blood thinning).....	<input type="checkbox"/>	<input type="checkbox"/>	Gastroesophageal reflux disease (GORD).....	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory Bowel disease	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bruising or bleeding.....	<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"/>	Treatment for cancer (type/region).....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes or family history of diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergy or reaction to any medicine (including	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, jaundice or liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other antibiotic).....	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract/Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to any foods,chemical or substance	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	(such as chlorine/latex/antiseptics/elastoplast)	<input type="checkbox"/>	<input type="checkbox"/>
Neck/Jaw or Shoulder damage or pain...	<input type="checkbox"/>	<input type="checkbox"/>	Transplanted organ/bone marrow/stem cells.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy (Fits)	<input type="checkbox"/>	<input type="checkbox"/>	Snoring/Sleep Apnoea	<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 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.

Patient Signature (Parent or guardian if under 18 years) Date

Dentist Signature Date

Information Reviewed – TO BE SIGNED AT FUTURE VISITS

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

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