Medical History Questionnaire

Title Dr / Mr / Mrs / Miss / Ms/ Other

Surname _____ First name _____ Date of birth ___/___/ _____

Preferred name _____

Home address _____

_____ Postcode _____

Postal address _____ Postcode _____

Phone (Mob) _____ (Hm) _____ (Wk) _____

Email _____

Health fund for dental cover _____ Membership No. _____ Patient ID. _____

Medicare Card No. _____ Veterans' Affairs Card No. _____

Occupation _____

Emergency contact _____ Relationship to patient _____ Contact No. _____

Person responsible for account (must be completed if patient under 16, if same as above please tick here ☐)

Name _____ Relationship to patient _____

Address _____ Postcode _____

Phone (Mob) _____ (Hm) _____ (Wk) _____

If third party, insurance company/employer responsible for account _____

Medical Questionnaire – Private and Confidential

Please answer these questions fully or discuss them with your dentist. Information about your medical history is for your dentist's use only.

Past/Current medical conditions:

Are you receiving any medical treatment at present Y ☐ N ☐ Details _____

Have you had any serious or long standing illness Y ☐ N ☐ Details _____

Have you ever been hospitalised Y ☐ N ☐ Details _____

Please indicate if you have EVER had any of the following:

Any heart complaint/treatment	Y ☐	N ☐	Tuberculosis	Y ☐	N ☐
Rheumatic fever or heart valve surgery	Y ☐	N ☐	Any nervous system disorder	Y ☐	N ☐
High or low blood pressure	Y ☐	N ☐	Gastric ulcer	Y ☐	N ☐
Blood Disorders	Y ☐	N ☐	Asthma/Bronchitis /lung conditions	Y ☐	N ☐
Anti-coagulant therapy	Y ☐	N ☐	Radiation therapy/chemotherapy	Y ☐	N ☐
Joint replacement surgery	Y ☐	N ☐	Thyroid disease	Y ☐	N ☐
Osteoporosis or low bone density	Y ☐	N ☐	Hepatitis, jaundice or liver disease	Y ☐	N ☐
Epilepsy	Y ☐	N ☐	Treatment for any form of Cancer	Y ☐	N ☐
Diabetes	Y ☐	N ☐	Transplanted organ or bone marrow	Y ☐	N ☐
HIV	Y ☐	N ☐	Pregnant (when due) _____	Y ☐	N ☐
			Other _____		

Do you smoke Y ☐ N ☐ Social ☐

Current medications (prescription, over the counter, herbal) _____

_____

Allergies Nil known ☐ Yes ☐ - Details _____

Medical practitioner _____ Suburb _____