

MEDICAL HISTORY QUESTIONNAIRE

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Dr/Mr/Mrs/Ms/Miss/Mst Last Name _____ First Name _____

(please circle)

Date of Birth ____/____/____ Occupation _____ Email Address _____

Street Address _____ Suburb _____ Post Code _____

Tel: Home _____ Mobile _____ Work _____

Contact in case of emergency _____ Relationship _____ Phone _____

Are you in a Private Health Fund? **Yes / No** If Yes, which one? _____

How did you find us? (please circle)

Yellow Pages	Yellow pages online	Internet Search	Local Paper
Health Fund	Flyers	Signage	
Other dentist (name) _____		School (name) _____	
Personal referral (name) _____			

Do you feel nervous about your dental treatment? (No) **1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** (Extremely) (please circle)

Who is your usual GP? _____ Suburb _____ Tel _____

Are you currently taking any medication, drugs or pills? **Yes / No**

If Yes, please list medication and dosages _____

(if not enough space available, please write on back of this form)

Are you allergic to any drugs, medicines or materials (e.g. Penicillin, Aspirin, Nurofen, Panadeine)? **Yes / No**

If Yes, please list _____

Do you normally require antibiotic cover before dental treatment? **Yes / No**

Are you currently undergoing medical treatment? **Yes / No**

Do you smoke? **Yes / No**

Ladies – Are you nursing? **Yes/No** Are you pregnant? **Yes / No / Maybe**

If Yes, when are you due? _____

Please indicate below if you have had, or have at present, any of the following **(please circle condition as well as Yes/No)**

High/Low Blood Pressure	Yes/No	Epilepsy	Yes/No	Artificial Joint (Hip, Knee)	Yes/No
Rheumatic Fever	Yes/No	Diabetes	Yes/No	Heart Complaint/Chest Pain	Yes/No
Steroid Therapy	Yes/No	Thyroid Disease	Yes/No	Heart Valve Disorder	Yes/No
Chemotherapy	Yes/No	Radiation Therapy	Yes/No	Congenital Heart Disease	Yes/No
Sinus Problems	Yes/No	Stroke	Yes/No	Artificial Valve	Yes/No
Cardiac Pacemaker	Yes/No	Hepatitis A, B or C	Yes/No	Mitral Valve Prolapse	Yes/No
Stomach Ulcers	Yes/No	Other Liver Disease	Yes/No	Heart Murmur/Surgery/Attack	Yes/No
Asthma/Hay Fever	Yes/No	Contact with HIV/AIDS	Yes/No	Bleeding Disorder eg. Haemophilia	Yes/No
Tuberculosis	Yes/No	Emphysema	Yes/No	Transplanted Organ or Marrow	Yes/No
Kidney Disease	Yes/No	Arthritis/Rheumatism	Yes/No		

I understand that all treatment is to be paid for on the day of treatment as no credit is given, and all information collected will be treated in confidence. **Yes / No**

If under 18, Parent/Guardian Name _____ **(Parent must accompany to initial visit)**

Patient / Parent / Guardian Signature _____ Date ____/____/____

(please circle)

Dentist Signature _____ Date ____/____/____