

Patient Personal Private & Confidential Medical Questionnaire

Name (Mr/Mrs/Miss/Ms/Dr/Other) _____
(First Names) (Family Name)

Preferred Name _____ **Date of Birth** _____

Address _____ **Postcode** _____

Phone (Home) _____ **Phone (Work)** _____ **Phone (Mobile)** _____

E-mail _____ **Occupation** _____

Emergency Contact _____ **Relationship** _____ **Phone** _____

Person responsible for payment of accounts _____ **Private Health Fund** _____

How did you hear about our practice? _____

Reason for today's visit? _____

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 _____
 Number/Location of 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 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.

If you are not taking any medications please put N/A

<u>Drug Name</u>	<u>Dosage</u>	<u>Duration of Treatment</u>	<u>Purpose/Condition</u>

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

If you have no allergies please put N/A

<u>Drug Name</u>	<u>Nature of Reaction</u>	<u>How Long Ago</u>

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

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. You can find a copy of our Privacy Policy on our website <https://www.crestmeaddental.com.au/privacy>. If you have any questions please ask one of our staff members about how we will use your personal information.

..... Please turn over →

Please indicate YES or NO if you have ever had any of the following:

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

Do you suffer from any illness not listed above or carry any infectious disease? Y N

If yes, please provide details _____

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

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 _____

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