QUESTIONNAIRE

We would like to welcome you to our practice. To assist us in providing you with the best possible treatment and standard of care, we ask that you complete this confidential medical history questionnaire.

Surname _____

First Name _____ Middle Name _____

Date of Birth _____

Address _____ Zip/Postcode _____

Phone Home _____ Work _____ Cell/Mobile _____

Work Place _____ Occupation _____

Emergency Contact Person _____ Phone number _____

Email Address _____ Drivers License Number _____

What is your preference for communication from our practice? (Please tick)

☐ Home Phone ☐ Work Phone ☐ Cell/Mobile SMS ☐ Email

Dental Fund/ Insurance Plan _____

Who recommended you to us _____

Have you been under the care of a medical doctor during the past two years? ☐

If **yes**, for what? _____

Doctor's Name _____ Phone _____

Address _____ State _____ Zip/Postcode _____

Have you taken any medication or drugs during the past two years? ☐

Are you taking any medication, drugs or pills now? ☐

If **yes**, please list name and dosage: _____

_____

Are you aware of having an allergic (or adverse) reaction to any medication or substance? ☐

If **yes**, please list _____

Have you been a patient in the hospital during the past five years? ☐

Indicate which of the following you have had, or have at present? If yes, please tick.

- ☐ Heart (surgery, disease, attack)
- ☐ Chest Pain
- ☐ Congenital Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Stroke
- ☐ Stomach Ulcers
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Glaucoma
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Tuberculosis
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Cold Sores/Fever Blisters
- ☐ Haemophilia
- ☐ Bruise easily
- ☐ Liver Disease
- ☐ Kidney Trouble
- ☐ Neurological Disorders

- ☐ Rheumatic Fever
- ☐ Arthritis/Rheumatism
- ☐ Cortisone Medicine
- ☐ Swollen Ankles
- ☐ Diet (Special/Restricted)
- ☐ Hepatitis
- ☐ Asthma
- ☐ Hay Fever
- ☐ Latex Sensitivity
- ☐ Allergies or Hives
- ☐ Sinus Troubles
- ☐ HIV/AIDs
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Nervous/Anxious
- ☐ Artificial Joints (hip, knee, etc.)
- ☐ Tumours

Do you have or had any disease, condition or problem not listed? ☐

If **yes**, please list _____

Are you:
- ☐ **Pregnant?** If **yes**, how many months _____
- ☐ **Nursing**
- ☐ **Taking birth control pills?**
- ☐ **Do you think you may be pregnant?**

Date of last dental visit _____ Last dental cleaning _____ Last full mouth x-rays _____

What was done on your last dental visit? _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Do you have any dental problems now? ☐

If **yes**, please describe _____

Are any of your teeth sensitive to:
- ☐ Hot or cold?
- ☐ Sweets?
- ☐ Biting or Chewing?
- ☐ Have you noticed any mouth odours or bad taste?
- ☐ Being ground or the bite adjusted?
- ☐ Do you frequently get sores, blisters or any other oral lesions?

Have you ever had:
- ☐ Dental Implants?
- ☐ Orthodontic Treatment?
- ☐ Oral Surgery?
- ☐ Periodontal or Gum Treatment?
- ☐ Your teeth ground or the bite adjusted?
- ☐ A bite plate or mouth guard?
- ☐ A serious injury to the mouth or head?

Do your gums bleed or hurt ☐

Have your parents experienced gum disease or tooth loss ☐

Have you noticed any loose teeth or change in your bite? ☐

If **so**, please describe, including cause? _____

Does food tend to become caught between your teeth? ☐

If **yes**, where? _____

Are you satisfied with your teeth's appearance? ☐

Would you like to keep all of your teeth all your life? ☐

Do you feel nervous about having dental treatment? ☐

If **so**, what is your biggest concern _____

_____

Have you ever had an upsetting dental experience? ☐

If **yes** please describe _____

_____

Patient/ Guardian Signature _____ Date _____

Print Form