Medical History Questionnaire

Smile Inn DENTISTRY

PATIENT DETAILS UPDATE FORM

Please be assured that this form is maintained in accordance with State and Federal Privacy Legislation

TITLE:_____ GIVEN NAME: _____ SURNAME: _____GENDER: M ☐ F ☐

PREFERRED NAME: _____ DATE OF BIRTH: _____ OCCUPATION:_____

ADDRESS: _____ SUBURB: _____ POST CODE: _____

HOME PHONE: _____ MOBILE: _____ WORK: _____

EMAIL: _____ PRIVATE HEALTH FUND: _____

EMERGENCY CONTACT: _____ PHONE: _____ RELATIONSHIP: _____

REFERRAL INFORMATION - How did you hear about us?

☐ Existing Patient ☐ Google ☐ Facebook ☐ NSW Health Voucher

☐ Signage ☐ Word of Mouth ☐ Staff Member ☐ Other _____

Referred by an existing patient? Name: _____

DENTAL HISTORY

Reason for attending today? _____ Last dental visit? _____

Are any of your teeth sensitive to? ☐ Hot ☐ Cold ☐ Chewing ☐ Sweet

Does food get caught between your teeth? ☐ Yes ☐ No

Do your gums hurt or bleed when you clean your teeth? ☐ Yes ☐ No

Do you suffer from bad breath? ☐ Yes ☐ No

Do you suffer from any of the following:-

☐ Headaches

☐ Clicking Jaw/ Jaw Pain/ Facial Pain

How often do you brush a day? ☐ 1 ☐ 2 ☐ 3

How often do you floss/ interdental brush? _____

Is there anything that concerns you about the appearance of your teeth?

_____

_____

Is there anything you would like us to know about your previous dental experiences (good or bad)?

_____

_____

Do you have any other dental concerns?

_____

_____

PLEASE TURN OVER

02 9554 3180 25 Shaw Street Bexley North NSW 2207 info@smileinndentistry.com.au www.smileinndentistry.com.au

MEDICAL HISTORY

How do you rate your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Who is your General Practitioner: _____

PHONE: _____

Have you had or are you suffering from any of the following? (Please Tick)

- ☐ Acid Reflux/ Digestion problems
- ☐ Anaemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints (hip, knee etc)
- ☐ Asthma/ Respiratory Problems
- ☐ Blood Disorder
- ☐ Bone Marrow Transplant
- ☐ Cancer Type_____
- ☐ Chemo/ Radiation Therapy
- ☐ Diabetes
- ☐ Dizziness/ Fainting
- ☐ Drug Dependence/ Alcoholism
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Head/ Neck Injury
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Herpes
- ☐ HIV/ Aids
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Illness/ Depression
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Sinus Problems
- ☐ Snoring/ Sleep Apnoea
- ☐ Steroid Therapy
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Transplanted Organs
- ☐ Tuberculosis
- ☐ Ulcers ☐ Mouth ☐ Stomach
- ☐ Other (Please Specify):-

_____

Please list all the medications (if any) you are currently taking, and the reason for taking each:-

Medication	Reason for taking Medication

Have you ever taken any Osteoporosis medication? ☐ Yes ☐ No

Do you smoke? If yes, how much? _____ ☐ Yes ☐ No

If female, are you pregnant? ☐ Yes ☐ No

Are you **Allergic** to anything? eg: **Latex, Penicillin, Amoxil, Peanuts, Local Anaesthetic** etc. (Please specify):-

_____

I have accurately completed this pre-clinical form to the best of my knowledge. I hereby give my authority for any treatment agreed upon by me, to be carried out by the dentists and their staff and I assume full financial responsibility for said treatments.

PATIENT SIGNATURE:_____ PRINT NAME: _____ DATE: _____

CHECKED BY SIGNATURE:_____ PRINT NAME: _____ DATE: _____

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