Gentle Family Dentist

Date

Please assist us in providing you with the best possible treatment & standard of care, by completing this

CONFIDENTIAL MEDICAL QUESTIONNAIRE

Personal Details:

DOB _____ Home Phone _____
Name _____ Work Phone _____
Address _____ Mobile Phone _____
_____ Email _____
Please Circle Mr Mrs Ms Miss Dr If under 18 – Parents name _____
Emergency Contact: Name_____ Phone _____
Dental Health Fund/Insurance (CIRCLE) NONE MBP BUPA HCF/MU OTHER _____
If Veteran Affairs No _____
How did you hear about us? (CIRCLE) Newspaper Ad Yellow Pages Online/Website Phone book Word of Mouth
What is your preference for communication from our practice? (Please circle)
Home Phone Work Phone Mobile Text/SMS Email

Cultural Background:

Do you identify as Aboriginal or Torres Strait Islander origin? NO
YES Aboriginal YES Torres Strait Islander YES both Aboriginal and Torres Strait Islander
Other cultural background (eg Mediterranean, Asian, African) If YES - Country of birth_____
Is English your first language? YES/NO If NO, do you need help with translation? YES/NO
If YES, do you have a friend or relative who can accompany you YES?NO
If YES, Name _____ Phone _____
If NO do you need a Translator service? YES/NO

Medical History:

Have you been under the care of a medical doctor during the past two years? YES/NO
If YES, for what _____
_____
_____
If NO when was the last time you visited a medical doctor for a medical check?_____
Doctor's Name _____Phone_____
Address_____
_____
Have you been a patient in a hospital during the past five years? YES/NO If YES, note details
_____
_____
Have you taken any medication or drugs during the past two years? YES/NO If YES, note below
Are you taking any medication, drugs or pills now? YES/NO 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_____
_____
_____
Indicate which of the following you have had, or have at present?

	PLEASE CIRCLE – YES/NO	**ADD ANY RELEVANT DETAILS**
Heart (surgery, disease, attack)	YES/NO	_____
Heart valve disorder	YES/NO	_____
High blood pressure	YES/NO	_____
Low blood pressure	YES/NO	_____
Stroke	YES/NO	_____
Rheumatic Fever	YES/NO	_____

Asthma YES/NO _____
Epilepsy or Seizures YES/NO _____
Arthritis/Rheumatism YES/NO _____
Hay Fever YES/NO _____
Sinus Problems YES/NO _____
Fainting or Dizzy Spells YES/NO _____
Cortisone Medicine YES/NO _____
Nervous/Anxious Condition YES/NO _____
Swollen Ankles YES/NO _____
Artificial Joints (hip, knee, etc) YES/NO _____
Contact with HIV/AIDs YES/NO _____
Excessive Bleeding YES/NO _____
Tumours/Cancer YES/NO _____
Tuberculosis YES/NO _____
Kidney Disease YES/NO _____
Thyroid Disease YES/NO _____
Anaemia YES/NO _____
An Undiagnosed Cough YES/NO _____
Hepatitis (A,B, or C) YES/NO _____
Diabetes Type 1 or 2 YES/NO _____
Have you ever smoked? YES/NO If YES for how long?_____
If you've QUIT, when? YES/NO Date/Year _____
Any other disease/condition/problem? YES/NO _____

For Females:

Are you pregnant? YES/NO If YES, how many months? _____
Nursing? YES/NO _____
Taking birth control pills? YES/NO _____
Do you think you may be pregnant? YES/NO _____

Dental History:

What was the date of your last dental visit _____, your last dental cleaning _____, your last full mouth x-rays _____?
What was done on your last dental visit?_____
_____
How often do you have dental exams?_____ How often do you brush your teeth? _____
How often do you floss?_____
Do you have any dental problems now? YES/NO If yes, please describe _____
_____
Are any of your teeth sensitive to: Hot or cold YES/NO Sweets YES/NO Chewing YES/NO Biting YES/NO
Have you ever had - Dental Implants YES/NO _____ Oral Surgery YES/NO _____
Periodontal or Gum Treatment YES/NO _____ Teeth being ground or bite adjusted YES/NO
A bite plate or mouth guard YES/NO _____ A serious mouth or head injury YES/NO
_____
Have you noticed any mouth odours or bad taste? YES/NO _____
Do you frequently get sores, blisters or any other oral lesions? YES/NO _____
Do your gums bleed or hurt? YES/NO _____
Have your parents experienced gum disease or tooth loss? YES/NO _____
Have you noticed any loose teeth or change in your bite? YES/NO _____
If YES, please describe, including cause? _____
Does food tend to become caught between your teeth? YES/NO If YES, where? _____
_____
Are you satisfied with your teeth's appearance? YES/NO_____
Would you like to keep all of your teeth all your life? YES/NO_____
Do you feel nervous about having dental treatment? YES/NO If YES, what is your biggest concern?
_____
_____
Have you ever had an upsetting dental experience? YES/NO If YES, please describe _____
_____

Consent:

Patient/Guardian Signature_____Date_____

Please inform us of any changes to this Medical Questionnaire in the future.