MEDICAL & DENTAL QUESTIONNAIRE

PRIVATE & CONFIDENTIAL

cotton tree implant dentistry & perio care

Welcome to our Practice

Please answer these questions as completely as possible;
it will greatly assist us to provide the best dental treatment for you.

PRIVACY STATEMENT: We value your privacy. All of the information which you provide is treated in accordance with our Privacy Policy. Please take the time to read through our Privacy Policy before answering the questionnaire and speak to one of our staff members if you have any concerns.

Name

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

Address

Postcode

Date of Birth Gender Occupation

Phone (Home) Phone (Work) Phone (Mobile)

Email

Emergency Contact Relationship Phone

Person responsible for payment of accounts

Private Health Fund / DVA (if applicable)

Who is your usual general dentist?

Are you receiving any medical treatment at present?

Name of your medical practitioner/specialist

Have you have ever had any of the following **medical conditions or treatment**?

	Y	N		Y	N
Rheumatic fever	☐	☐	Epilepsy/Seizures	☐	☐
Heart condition/cardiac surgery/pacemaker	☐	☐	Thyroid disease (including goitre)	☐	☐
Heart valve replacement	☐	☐	Tuberculosis (TB)	☐	☐
High or low blood pressure	☐	☐	Asthma/Bronchitis/lung conditions	☐	☐
Blood disorders	☐	☐	Nervous system disorder	☐	☐
Blood borne viruses (including HIV/AIDS)	☐	☐	Anxiety/Depression	☐	☐
Hepatitis (indicate type)	☐	☐	Gastroesophageal reflux disease (GORD)	☐	☐
Jaundice or liver disease	☐	☐	Treatment for cancer (type/region)	☐	☐
Diabetes or family history of diabetes	☐	☐	Chemotherapy/Radiation therapy	☐	☐
Osteoporosis or low bone density	☐	☐	Transplanted organ/bone marrow/stem cells	☐	☐
Rheumatoid arthritis/Lupus (SLE)/Polymyalgia	☐	☐	Snoring/Sleep Apnoea	☐	☐
Joint replacement surgery	☐	☐	Any infectious disease	☐	☐
Jaw, neck or shoulder injury or pain	☐	☐	Illness not listed above	☐	☐

If yes to any of the above, please provide further details if required

PLEASE TURN OVER

Please list any **medications** you are currently taking, including herbal preparations, vitamins, supplements, cold/flu treatments, sleeping pills, pain relievers, injections, implants, so we can take appropriate precautions and avoid drug interactions

Do you have any **allergies**?

Have you ever **smoked/vaped**? Y ☐ N ☐ Approx. date if quit

LADIES: Are you **pregnant** or is there a chance you could be pregnant?
Y ☐ N ☐ If yes, date due Are you currently **breastfeeding**? Y ☐ N ☐

Have you ever had periodontal treatment in the past?

What is your home oral hygiene routine? (eg. Electric or manual toothbrush 2xday, flossing, interdental brushes)

DECLARATION:

In signing this form I acknowledge that it represents an accurate medical history. I will advise my dentist of any changes to my medical history in the future.

I have read the privacy document provided by this practice.

Patient Signature (Parent or guardian if under 18 years) Date

Clinicians Signature Date

Practice Use Only: Review of Information

Patient Signature: Date:

Clinicians Comment:

Signature: Date:

Patient Signature: Date:

Clinicians Comment:

Signature Date:

Patient Signature: Date:

Clinicians Comment:

Signature: Date:

PLEASE TURN OVER