East Keilor Dental
27 McFarlane Street, East Keilor 3033
(ph) 9337 4076
reception@eastkeilordental.com.au

Medical History Questionnaire

Full name: Mr. Mrs. Ms. Miss. Dr. _____ Date of birth: ___/___/_____
Home Address: _____ Postcode: _____
Phone: (home)_____ (wk) _____ (mob) _____
Email: _____
Emergency contact: _____ Relationship: _____ Ph: _____
Are you in a dental fund? _____ Who referred you to our practice? _____
Are you an Aboriginal or Torres Straight Islander? Y☐ N ☐ Do you require an interpreter? Y☐ N ☐

MEDICAL HISTORY:

Are you having any problems with your health? Y☐ N ☐ details _____
Have you been hospitalised within the last 5 years? Y☐ N ☐ details _____
Have you ever received blood or had a blood transfusion Y☐ N ☐ details _____
Have you been tested for AIDS, hepatitis, infectious disease Y☐ N ☐ results _____
Have you EVER had, or been suspected of having, any of the following:

High Blood pressure	Y☐ N ☐	Heart disease/murmur	Y☐ N ☐
Stroke	Y☐ N ☐	Rheumatic fever	Y☐ N ☐
Unusual/excessive bleeding	Y☐ N ☐	Anaemia	Y☐ N ☐
Jaundice, hepatitis, liver disease	Y☐ N ☐	Diabetes	Y☐ N ☐
Epilepsy or seizure disorder	Y☐ N ☐	Thyroid condition	Y☐ N ☐
Kidney disease	Y☐ N ☐	Bone disease (osteoporosis/Pagets)	Y☐ N ☐
Tonsilitis, sinusitis, nasal polyps	Y☐ N ☐	Artificial heart valve or pacemaker	Y☐ N ☐
Prosthesis (eg knee/hip replacement)	Y☐ N ☐	Snoring, sleep apnoea or CPAP	Y☐ N ☐
Anxiety or depression	Y☐ N ☐	Eating disorder	Y☐ N ☐
Asthma	Y☐ N ☐	Do you smoke	Y☐ N ☐
Are you pregnant (*women only*)	Y☐ N ☐	If yes, how many: _____	

Other medical issues: _____

Have you had an unusual reaction or are you allergic to any of the following:

Latex	Y☐ N ☐	Penicillin	Y☐ N ☐	Aspirin	Y☐ N ☐
Codeine	Y☐ N ☐	Dental anaesthetics	Y☐ N ☐	Milk Protein	Y☐ N ☐

Other _____

Are you taking any medications? Y☐ N ☐ If yes, please list below:

Medication	Dosage
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

PTO

DENTAL HISTORY

What is your main reason for attending _____

_____

Do you have a history of any of the following:

Dental cosmetic concerns	Y□ N □	Bleeding gums	Y□ N □
Stained teeth	Y□ N □	Gum disease	Y□ N □
Discoloured/rough fillings	Y□ N □	Blisters, sores, ulcers in the mouth	Y□ N □
Sensitive Teeth (hot/cold/sweet)	Y□ N □	Tongue coating	Y□ N □
Clenching or grinding	Y□ N □	Dry mouth	Y□ N □
Chronic face pain, jaw pain/click	Y□ N □	Bad breath	Y□ N □
Difficulty opening mouth/chewing	Y□ N □	Bothersome food packing	Y□ N □
Do you wake with head/neck pain	Y□ N □		

Please provide the name, address and phone number of your regular Doctor:

_____

_____

CONSENT

I have read and understood the above questionnaire and I have answered all questions truthfully to the best of my ability. I also consent to notes, x-rays & models relating to my treatment being sent to other practitioners, as required, to facilitate my management. I understand that my medical and dental history will be kept private and confidential as per East Keilor Dental's privacy statement (available in the reception area and on the practice website).

PLEASE NOTE: This form will be electronically copied to your clinical record file and will subsequently be destroyed. This form is a guide and you should discuss any relevant matters with your dentist prior to the commencement of any treatment.

Name: _____

□ Parent

□ Guardian

Signature: _____ Date: ___ / ___ / _____

Sighted by Dentist:_____

PLEASE ADVISE OF ANY CHANGES TO THE ABOVE AT FUTURE VISITS.