Wanneroo Dental Centre

MEDICAL QUESTIONNAIRE

(The state of your health may have a very significant effect on your dental care.)

PATIENT INFORMATION			
Title:	**First Name:**	**Surname:**	
Preferred Name:	**Date of Birth:**	**Health Fund:**	
Address:			
Email:	**Medicare Number:**	**IRN:**	
Home Phone:	**Mobile:**	**Work Phone:**	
Occupation:	**Employer:**		

EMERGENCY & 2nd CONTACT INFORMATION	
2nd Contact (if unable to reach you): **Name & Relationship to you:**	**2nd contact telephone:**
Emergency Contact (if same as 2nd contact please write "as above"): **Name & Relationship to you:**	**Emergency telephone:**

OTHER INFORMATION	
If new, how did you hear about us:	
Name of your Medical Practitioner/Specialist:	
Are you receiving any **medical treatment** at present? Y❑ N❑	Have you been treated in a **hospital** recently? Y ❑ N ❑

Please indicate **Y** or **N** if you have had any of the following: -

Infective Endocarditis	Y ❑	N ❑	Hepatitis/jaundice or liver disease	Y ❑	N ❑
Any heart complaint/treatment	Y ❑	N ❑	Epilepsy (Fits)	Y ❑	N ❑
A cardiac pacemaker	Y ❑	N ❑	Thyroid disease	Y ❑	N ❑
High or low blood pressure	Y ❑	N ❑	Anxiety / Depression	Y ❑	N ❑
Blood thinning medication	Y ❑	N ❑	Asthma	Y ❑	N ❑
Blood disorders	Y ❑	N ❑	Nervous system disorder	Y ❑	N ❑
Excessive bruising or bleeding	Y ❑	N ❑	Gastric Ulcer/Reflux	Y ❑	N ❑
Lung Disease	Y ❑	N ❑	Sleep Apnoea	Y ❑	N ❑
Osteoporosis	Y ❑	N ❑	Cancer Treatment	Y ❑	N ❑
Diabetes	Y ❑	N ❑	When? _____		
Family history of Diabetes	Y ❑	N ❑	Radiation Therapy	Y ❑	N ❑
Joint replacement surgery	Y ❑	N ❑	Allergy or reactions	Y ❑	N ❑
When?_____			Please list_____		

Do you smoke? Y ❑ N ❑ How much do you smoke per day? _____

Have you ever smoked? Y ❑ N ❑ If yes, for how long? _____

How many units of alcohol do you consume per week? _____

FEMALES: Are you pregnant? Y ❑ N ❑ Due Date?_____ Are you breast feeding Y ❑ N ❑

Please list below ANY MEDICATIONS or INJECTIONS you are currently on

(Include oral contraception, hormone replacement therapy, herbal, naturopathic or "over the counter" remedies)

_____

_____

If no medications/injections please circle NONE

All payment is required on the day of treatment

Signed: _____ Date: _____ Dentist Reviewed: _____

Changes? Y ❑ N ❑ Signed: _____ Date: _____ Dentist:_____

Changes? Y ❑ N ❑ Signed: _____ Date: _____ Dentist:_____

Changes? Y ❑ N ❑ Signed: _____ Date: _____ Dentist:_____