MANNING DENTAL

PATIENT PERSONAL & MEDICAL QUESTIONNAIRE

PRIVATE & CONFIDENTIAL

Title: _____ First Names: _____ Family Name: _____

Address: _____

_____ Postcode: _____

Date of Birth: _____ Phone (Home): _____ Phone (Work): _____

Phone (Mobile): _____ Preferred Daytime Contact: ☐ Home ☐ Work ☐ Mobile

E-mail: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Person responsible for payment of accounts: _____ Private Health Fund (if applicable): _____

How did you hear about us? _____

The state of your health may have a very significant effect on your dental care.
Please answer these questions fully or discuss them with your dentist:

- I have private and confidential medical matters which I wish to discuss with the dentist ☐ Yes ☐ No
- Are you receiving any medical treatment at present? _____ ☐ Yes ☐ No
- Name of your medical practitioner/specialist _____ ☐ Yes ☐ No
- Have you ever been in hospital? If yes, nature of hospitalisation and dates: ☐ Yes ☐ No

_____

_____

- Some medicines may interfere with your dental treatment or react with medicaments used by your dentist. It is important that your dentist knows precisely what medications (if any) that you are taking.

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

Drug Name	Dosage	Duration of Treatment	Purpose/Condition

Please list any known ALLERGIES or ADVERSE REACTIONS to drugs (especially antibiotics eg. penicillin), medicines, antiseptics, local anaesthetics, latex, preservatives that we should know about.

Drug Name	Nature of Reaction	How Long Ago

If you are in any doubt about your medication, please bring a Pharmacy Medication Summary or the bottle or packet(s) to the practice to show the dentist.

Please indicate YES or NO if you have ever had any of the following:

	Y	N		Y	N
Rheumatic fever	☐	☐	Jaw, neck or shoulder injury or pain	☐	☐
Heart condition/cardiac surgery/pacemaker	☐	☐	Epilepsy/Seizures	☐	☐
Heart valve replacement	☐	☐	Thyroid disease (including goitre)	☐	☐
High or low blood pressure	☐	☐	Tuberculosis (TB)	☐	☐
Blood disorders	☐	☐	Asthma/Bronchitis/lung conditions	☐	☐
Excessive bruising or bleeding	☐	☐	Nervous system disorder	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	Anxiety/Depression	☐	☐
Kidney/renal disease	☐	☐	Gastroesophageal reflux disease (GORD)	☐	☐
Diabetes	☐	☐	Cancer or malignancy of any kind	☐	☐
Osteoporosis or low bone density	☐	☐	Chemotherapy/Radiation therapy	☐	☐
Rheumatoid arthritis/Lupus (SLE)/Polymyalgia	☐	☐	Transplanted organ/bone marrow/stem cells	☐	☐
Joint replacement surgery	☐	☐	Snoring/Sleep Apnoea	☐	☐

Have you ever smoked? ☐ Yes ☐ No Approx date if quit _____

Do you currently smoke or vape? ☐ Yes ☐ No If yes, for how long? _____

How much do you smoke _____ per day

Have you ever used illicit substances and/or recreational drugs? ☐ Yes ☐ No If yes, when? ☐ Recent ☐ More than 1 yr ago

Do you consume alcohol? ☐ Yes ☐ No

Do you suffer from any illness not listed above or carry any infectious disease? ☐ Yes ☐ No

If yes, please provide details _____

Females: Are you pregnant or is there a chance you could be pregnant? ☐ Yes ☐ No If yes, date due _____

Are you currently breastfeeding? ☐ Yes ☐ No

DECLARATION

In signing this form I acknowledge that this represents an accurate medical history (Parent or guardian if under 18 years).
I will advise my dentist of any changes to my medical history in the future.
I understand that all medical details will be treated with complete professional confidentiality.
I have read the privacy document provided by this practice.

Patient Signature		**Date**		**Dentist Signature**		**Date**	

(Parent or guardian if under 18 years)

Practice Use Only: Review of Information

Patient Signature:		Date:		Patient Signature:		Date:	
Dentist Comment:				Dentist Comment:			
Signature		Date:		Signature		Date:	