Nundah General & Emergency DENTAL

CONFIDENTIAL PATIENT QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____
FIRST SURNAME

HOME ADDRESS: _____

_____

MOBILE PHONE: _____

OCCUPATION/SCHOOL: _____

EMAIL ADDRESS: _____

PERSON TO CONTACT **IN CASE OF EMERGENCY**:

NAME/RELATION: _____ CONTACT NUMBER: _____

MEDICAL DOCTOR'S NAME: _____ CONTACT NUMBER (IF KNOWN): _____

MEDICAL HISTORY:

1. Are you receiving any medical treatment at present? YES / NO
   Details: _____
2. Have you been a patient in the hospital during the past 2 years? YES / NO
   Details: _____
3. Have you experienced any allergies or unusual effects from any medications or anesthetics? YES / NO
   Details: _____
4. Please list any medications you are currently taking:
   _____
5. Have you had any of the following, (please circle)?

Rheumatic Fever	Epilepsy	Thyroid problems
Heart Problems / Medical Device	Severe Headache	Diabetes
High blood pressure	Fainting / Dizzy spells	Kidney trouble
Stroke	Depressive illness	Gastric problems
Anemia	Cold sores	Liver problems
Asthma / Bronchitis / Chest problems	Bone / Joint Disease / Arthritis	Hepatitis A / B / C
Radiation / Chemotherapy	Drug dependence / Smoking	Infectious diseases

6. Have you had prosthetic surgery or hip replacement? Details: _____ YES / NO
7. Are you HIV-positive? YES / NO
8. Are you at risk of HIV exposure? Details: _____ YES / NO
9. **For women**, are you pregnant? How many weeks? _____ YES / NO

DENTAL HISTORY

10. Name or Date of last Dentist/dental visit: _____
11. Are you currently in pain? YES / NO
12. Have you had excessive bleeding or bruising from previous dental treatment? YES / NO
    Details: _____
13. Are you anxious or uncomfortable when having dental treatment? YES / NO

To the best of my knowledge, all the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

SIGNATURE: _____
PATIENT / PARENT / GUARDIAN

DATE: _____