PATIENT GENERAL MEDICAL AND HEALTH QUESTIONNAIRE PRIVATE AND CONFIDENTIAL

ROLEYSTONE DENTAL

Patient's Name ..... Patient Birth Date .....
(FIRST NAME) (FAMILY NAME) (DAY) (MONTH) (YEAR)

Address .....

..... Postcode.....

Phone (Preferred Contact) ..... E-mail.....

Occupation..... Employer.....

Emergency Contact ..... Relationship ..... Phone .....

Private Health Fund (if applicable) ..... Membership No .....

D.V.A No ..... Pension/Healthcare Card No .....

Whom may we thank for recommending you to our practice?.....

What is the name of your previous dental practice? .....Would you like us to transfer your previous dental records? Y/N

My Medical History

Please answers ALL questions by checking YES or NO and/or comments: Y N

- I have a private and confidential medical matter and would prefer to discuss with dentist ☐ ☐
- Who is your GP / Medical Specialist? .....
- Have you ever been in hospital? If yes, nature of hospitalization and dates: ☐ ☐

  .....

  .....
- Are you receiving any medical treatment at present? ☐ ☐
- Some medicines could have an important interrelationship with the dental treatment or react with medicament used by our dentists. It is important that we know what medications (if any) that you are taking.
  Please List any medications you are currently taking, or have been taking recently including herbal remedies, cold/flu treatments, pain relievers, injections, vitamins, supplements, sleeping pills, implants, so that we can take appropriate precautions to avoid drug interaction. **If unsure, please bring a Pharmacy Medication Summary or the medication packaging to show the dentist**.

Medicine Name	Dosage	Duration of Treatment	Purpose / Condition

Please List any known ALLERGIES or ADVERSE REACTIONS to drugs (especially antibiotics eg. penicillin), medicines, antiseptic, local anesthetics, preservatives that we should know about:

Drug Name	Allergy or Adverse Reaction	How Long Ago

..... PLEASE TURN OVER →

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

	Y	N
High or low blood pressure	☐	☐
Blood disorder	☐	☐
Excessive bruising / bleeding	☐	☐
Any heart condition/pacemaker	☐	☐
Rheumatic fever	☐	☐
Asthma / Bronchitis / lung conditions	☐	☐
Hepatitis / jaundice / liver disease	☐	☐
Kidney / renal disease	☐	☐
Osteoporosis	☐	☐
Joint replacement surgery	☐	☐
Epilepsy / seizure	☐	☐
Diabetes	☐	☐

	Y	N
Thyroid disease	☐	☐
Tuberculosis (TB)	☐	☐
Jaw / neck / shoulder injury or pain	☐	☐
Anxiety / depression	☐	☐
Nervous system disorder	☐	☐
Gastroesophageal reflux disease (GORD)	☐	☐
Chemotherapy / Radiation therapy	☐	☐
Rheumatoid arthritis /Lupus (SLE)/Polymyalgia	☐	☐
Allergy to any foods, chemical or substance	☐	☐
Transplanted organ / bone marrow / stem cells	☐	☐
Snoring / sleep apnea	☐	☐
Grinding / Clenching	☐	☐
AIDS / HIV positive	☐	☐

Do you suffer from any illness not listed above or carry any infectious disease? Y ☐ N☐

If yes, please provide details ……

……

Have you ever smoke? Y ☐ N☐ Approx. date if quit ……..

Do you currently smoke? Y ☐ N☐ If yes, for how long ……..

How much do you smoke .....per day

How often do you drink any alcohol? ……

What do you usually drink (Wine/Beer/Hard Liquor/Others)? ……..

How much do you usually drink most days? ……

Have you ever required any treatment for smoking / alcohol related diseases or condition? Y ☐ N☐

If yes, please provide details ……

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Have you ever used illicit substances and or recreational drugs? Y ☐ N☐ when was your last used……

FEMALES: Are you pregnant? Y ☐ N☐ If yes, due date …… Are you currently breastfeeding? Y ☐ N☐

DECLARATION:

In signing this form, I acknowledge that the questions on this form have been accurately answered to the best of my knowledge.
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.

Patient Signature …… Date ……

Dentist Signature …… Date ……

Patient Signature …… Date……

Patient Signature…… Date……