Shire Dental Centre

The Team at Shire Dental Centre would like to welcome you to our practice.

To assist us in providing you with optimal care we ask that you please complete this confidential medical history questionnaire.

Personal Details

Patient Name: _____
Title Surname First Name Middle Name

Preferred Name: _____ Date of Birth: _____

Phone: (H): _____ (M) _____ (W) _____

Address: _____

Occupation: _____ Email address: _____

Phone number for confirmation of appointments: (please circle) Home Mobile (SMS) Work

- **Are you in a private health fund?** Y/N (If "Yes", please circle below)

BUPA HCF NIB AHM Medibank Defence Teachers Other: _____

- **How did you find us?**

Google Internet Letterbox drop Yellow pages online Advertisement Referral

Name of patient who referred you to our practice: _____

Please complete if the patient is under 18 years of age

- Parent/Guardian information

Name: _____ Relationship to patient: _____

Dental history

What is the reason for your visit today? _____

Date of last dental visit: _____Last dental clean: _____ Full mouth x-rays:_____

Are any of your teeth sensitive to:		**Do your gums hurt or bleed?**	Y/N
Hot/Cold?	Y/N	Have your parents experienced gum disease or tooth loss?	Y/N
Sweets ?	Y/N	Have you noticed loose teeth?	Y/N
Biting or chewing?	Y/N	Have you noticed bad breath or a bad taste in your mouth?	Y/N
Do you:		**Are you interested in:**	
Clench or grind your teeth?	Y/N	Teeth whitening	Y/N
Have clicking or popping of your jaw?	Y/N	Teeth straightening	Y/N
Have difficulty or pain with opening your mouth?	Y/N	Dental implants	Y/N

Medical History

Name of GP: _____ Phone number: _____

Address: _____

Are you taking any medications? Y/N
Please list name and dosage: _____

Are you allergic to any medications or substance? Y/N
If yes, please list: _____

Have you ever had any of the following? Please ☑ Yes

Heart (surgery/disease/attack)	☐	Latex sensitivity	☐	Epilepsy/Seizures	☐
Chest pain	☐	Sinus problems	☐	Stroke	☐
Congenital heart disease	☐	Hay fever	☐	Neurological disorder	☐
Rheumatic fever	☐			Fainting/Dizzy spells	☐
Heart murmur	☐	Diabetes	☐		
Mitral valve prolapsed	☐	Glaucoma	☐	Cancer	☐
Heart pacemaker	☐	Kidney problems	☐	Type: _____	
High blood pressure	☐	Stomach problems	☐	Radiotherapy	☐
				Chemotherapy	☐
Asthma	☐	Arthritis	☐		
Emphysema	☐	Artificial joints	☐	Infectious disease	☐
Chronic cough	☐	(Hip/knee etc)	☐	HIV/AIDS	☐
Tuberculosis	☐			Hepatitis	☐
		Liver disease	☐	Creutzfeldt Jakob Disease	
		Bleeding disorder	☐	(CJD)	☐

Do you have any other condition not listed? Y/N
If yes, please list_____

Name of Specialist: _____Phone number: _____

Have you been a patient in hospital for surgery? Y/N
If yes, for what condition _____

Women- Are you: Pregnant? Y/N If yes, how many months? _____
Nursing? Y/N
Taking birth control pills? Y/N

Do you smoke? Y/N If yes, how many per day?_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. To the best of my knowledge all the preceding information is true and correct. If any further information is needed you have permission to contact my health care provider, who may release information to you. If there are any changes in my medical history I will inform my dentist at the next appointment.

Patient/Guardian signature_____ **Date**_____