



**Medical History**

Please take time to complete this questionnaire prior to your appointment. Answer all questions as detailed as possible. All information will be treated with professional confidentiality.

FULL NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

POSTAL ADDRESS \_\_\_\_\_

TELEPHONE: HOME \_\_\_\_\_ MOBILE \_\_\_\_\_

WORK \_\_\_\_\_ DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

OCCUPATION \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR PRACTICE? \_\_\_\_\_

MEDICAL PRACTITIONER \_\_\_\_\_ PH: \_\_\_\_\_

ANY SPECIALIST PRACTITIONER \_\_\_\_\_ PH: \_\_\_\_\_

MEDICARE NUMBER \_\_\_\_\_ CARD POSITION: \_\_\_\_\_

**DO YOU SUFFER FROM ANY OF THE FOLLOWING?**

| <b>Please circle the correct alternative</b>          | <b>now</b> | <b>previously</b> | <b>-</b> | <b>update</b> | <b>update</b> |
|---|------------|-------------------|----------|---------------|---------------|
| 1. Heart disease/vascular disorder                    | yes        | yes               | no       | .....         | .....         |
| 2. Heart surgery                                      | yes        | yes               | no       | .....         | .....         |
| 3. High Blood Pressure                                | yes        | yes               | no       | .....         | .....         |
| 4. Blood Disease/Bleeding disorder                    | yes        | yes               | no       | .....         | .....         |
| 5. Rheumatic fever                                    | yes        | yes               | no       | .....         | .....         |
| 6. Arthritis  | yes        | yes               | no       | .....         | .....         |
| 7. Hepatitis A, B or C                                | yes        | yes               | no       | .....         | .....         |
| 8. Are you a carrier of Hepatitis                     | yes        | yes               | no       | .....         | .....         |
| 9. Thyroid disorder                                   | yes        | yes               | no       | .....         | .....         |
| 10. Asthma/Bronchitis/Other lung disorders            | yes        | yes               | no       | .....         | .....         |
| 11. Liver or Kidney Disease                           | yes        | yes               | no       | .....         | .....         |
| 12. Epilepsy  | yes        | yes               | no       | .....         | .....         |
| 13. Ulcers  | yes        | yes               | no       | .....         | .....         |
| 14. Diabetes  | yes        | yes               | no       | .....         | .....         |
| 15. Radiotherapy/Chemotherapy                         | yes        | yes               | no       | .....         | .....         |
| 16. Have you used intravenous drugs?                  | yes        | yes               | no       | .....         | .....         |
| 17. Are you pregnant?                                 | yes        | yes               | no       | .....         | .....         |
| 18. History of I.V or oral bisphosphonate use?        | yes        | yes               | no       | .....         | .....         |
| 19. History of antibiotics prior to dental treatment? | yes        | yes               | no       | .....         | .....         |
| 20. History of osteoporosis?                          | yes        | yes               | no       | .....         | .....         |
| 21. Any genetic related disorder                      | yes        | yes               | no       | .....         | .....         |

Other health problems

\_\_\_\_\_

\_\_\_\_\_

**DO YOU HAVE ANY ALLERGIES? IF SO PLEASE STATE:-**

.....

**ARE YOU CURRENTLY TAKING ANY MEDICATIONS? IF SO PLEASE STATE:-**

.....

**ARE YOU A SMOKER?      YES              NO              IF 'YES' HOW MANY A DAY .....**

**YOUR MAIN CONCERN/S IN SEEKING TREATMENT:**

.....

.....

**PLEASE INDICATE IF YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING:-**

- Jaw Problems/Headaches .....
- Sensitive teeth (hot or cold) .....
- Food Impaction/Food Trapping.....
- Toothache .....
- Bleeding Gums .....
- Missing or loose teeth .....
- Comments .....

**HOW DO YOU FEEL ABOUT THE APPEARANCE OF YOUR TEETH?**

I am happy about the appearance .....

Not great, but not a priority .....

I would like an improvement .....

Specifically, are you concerned with the:

- Colour of your teeth
- Shape
- Arrangement
- Show of too much soft tissue or gum
- Size of teeth
- Missing teeth
- Spacings
- Orthodontic Needs

**TEMPO-MANDIBULAR JOINTS (JAW JOINTS/FACIAL PAIN)**

**DO YOU HAVE:**

Frequent headaches or ringing in the ears? .....

A click or grate when you open or close your mouth? ..... LHS..... RHS..... BOTH.....

Pain from your joints or face? .....

A stiff or sore jaw in the morning? .....

A clenching or grinding habit? .....

A previous history of oro-facial trauma?.....

A history of back and/or neck problems?.....

A recent history of stressful life events ie. Marital breakdown or loss of spouse?.....

Has your jaw ever locked?.....

Do you wear a nightguard or occlusal splint?.....

**OTHER**

Are you nervous about dental treatment? .....

What concerns you most? .....

When did you last have radiographs (x-rays) taken of your mouth? .....

\*I consent for any photographic images taken throughout the duration of my treatment to be used, by Dr Dunn or Dr Lewis, for case presentations and in either print or electronic publications.

Signature.....Date.....