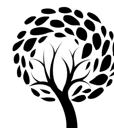
MEDICAL HISTORY QUESTIONNAIRE



Oakdale
Dental & Wellness Centre

☐ MR. ☐ MISS ☐ MRS. ☐ MS. ☐ DR.

FIRST NAME: ______________________ SURNAME ______________________

Preferred Name: ______________________

DATE OF BIRTH ___/___/___ *(DAY/MONTH/YEAR)*

ADDRESS (HOME): ______________________

____

PHONE: ______________________ MOBILE: ______________________

EMAIL: ______________________

ADDRESS (BUSINESS): ______________________

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PHONE: ______________________ OCCUPATION: ______________________

WHO OR HOW WERE YOU REFERRED YOU TO OUR OFFICE? ______________________

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: ______________________ RELATIONSHIP: ______________________

DAY-TIME PHONE: ______________________

NAME OF FAMILY DOCTOR: ______________________

PHONE: ______________________

ADDRESS: ______________________

____

The following information is required to enable us to provide you with the best possible care. All information is strictly private, and is protected by doctor-patient confidentiality. We will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year?
☐ YES ☐ NO ☐ NOT SURE/MAYBE If YES, why? ______________________

____

2. When was your last medical checkup? ______________________

3. Has there been any change in your general health in the past year? If yes, please explain.
☐ YES ☐ NO ☐ NOT SURE/MAYBE ______________________

____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.
☐ YES ☐ NO ☐ NOT SURE/MAYBE ______________________

____

5. Do you have any allergies? ☐ YES ☐ NO ☐ NOT SURE/MAYBE If you answered yes, please list using these categories: a) medications b) latex/rubber products c) other (e.g. hayfever, foods) ______________________

____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
☐ YES ☐ NO ☐ NOT SURE/MAYBE ______________________

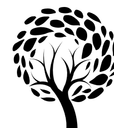
7. Do you have or have you ever had asthma? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

8. Do you have or have you ever had any heart or blood pressure problems? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

____

PHONE: 03 9078 7100
ADDRESS: 157 Mackie Road
Bentleigh East VIC 3165
WEBSITE: www.oakdale.net.au



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10. Do you have a prosthetic or artificial joint? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukaemia, AIDS, HIV infection, radiotherapy, chemotherapy? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

12. Have you ever had hepatitis, jaundice or liver disease? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

13. Do you have a bleeding problem or bleeding disorder? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
☐ YES ☐ NO ☐ NOT SURE/MAYBE ______________________

15. Do you have or have you ever had any of the following? Please tick.

☐ chest pain, angina	☐ rheumatic fever	☐ pacemaker	☐ steroid therapy	☐ seizures (epilepsy)
☐ heart attack	☐ mitral valve	☐ lung disease	☐ diabetes	☐ kidney disease
☐ stroke	☐ prolapse	☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease
☐ shortness of breath	☐ heart murmur	☐ cancer	☐ arthritis	☐ drug/alcohol dependency

☐ osteoporosis medications (eg. Fosamax, Actonel)

16. Are there any conditions or diseases not listed above that you have or have had? If so, what?
☐ YES ☐ NO ☐ NOT SURE/MAYBE ______________________

17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)
☐ YES ☐ NO ☐ NOT SURE/MAYBE ______________________

18. Do you smoke or chew tobacco products? ☐ YES ☐ NO ☐ NOT SURE/MAYBE ______________________

19. Are you nervous during dental treatment? ☐ YES ☐ NO ☐ NOT SURE/MAYBE ______________________

20. For women only:
Are you ☐ breastfeeding or ☐ pregnant?
If pregnant, what is the expected delivery date? ____/____/____ *(DAY/MONTH/YEAR)*

To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE: ______________________ DATE: ____/____/____

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