Oakdale
Dental & Wellness Centre

MEDICAL HISTORY QUESTIONAIRE

MR MISS MRS MS DR (PLEASE CIRCLE)

FIRST NAME - _____ PREFERRED NAME - _____
SURNAME - _____ DATE OF BIRTH - _____
ADDRESS (HOME) - _____P/CODE - _____
PHONE - _____ MOBILE - _____
EMAIL - _____
Are you happy to receive occasional generalized emails from us? Yes No
PREFERRED METHOD OF CONTACT? (PLEASE CIRCLE) SMS EMAIL PHONE CALL
OCCUPATION - _____
ADDRESS (BUSINESS) - _____P/CODE - _____
PHONE - _____
IN CASE OF EMERGENCY , WE SHOULD NOTIFY -
NAME - _____ RELATIONSHIP -_____
DAYTIME PHONE NUMBER - _____
NAME OF FAMILY DOCTOR - _____
ADDRESS - _____ P/CODE - _____
PHONE - _____
Do you have Private Health Insurance - (please circle) Yes No
If Yes, please provide Name of Health Insurer - _____
Member Number - _____ Series Number - _____
Who or how were you referred to this office**?**_____
_____

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, front and back. Please circle appropriate answer.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? (Please circle) Yes No
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 _____
_____
4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? (please circle) Yes No
If yes, please list - _____
_____
5. Do you have allergies? (please circle) 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?
   Yes No **If yes, please explain** _____
   _____
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 (ie. infected endocarditis) a heart condition from birth (ie. congenital heart disease) or a heart transplant? Yes No
   If yes, please explain - _____
10. Do you have a prosthetic or artificial joint? Yes No
    If yes, please list - _____
11. Do you have any conditions that could affect your immune system eg. Leukamia, 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 If yes, please list - _____
    _____
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 _____
15. Do you have or have you ever had any of the following? Please circle

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
Osteoporosis Medication Eg. Fosamax, Actonel	Heart Murmur	Cancer	Arthritis	Drug/Alcohol Dependency
Shortness of Breath				

16. Are there any conditions or diseases not listed above that you have or have had? If so, what ? Yes No _____
17. Are there any diseases or medical problems that run in your family? (eg Diabetes, Cancer or heart disease) Yes No Not sure/Maybe
    _____
18. Do you smoke or chew tobacco products? Yes No
19. Are you nervous during dental treatment? Yes No
20. **FOR WOMEN ONLY:**
    Are you breastfeeding? Yes No or Pregnant Yes No
    If pregnant, what is the expected delivery date? _____/_____/_____
    To the best of my knowledge, the above information is correct.
    PATIENT/PARENT/GUARDIAN SIGNATURE -_____
    DATE - _____

****CANCELLATION WITHIN 24 HOURS OF APPOINTMENT MAY INCUR A FEE**
In the event where your overdue account is referred to a collection agency and/or law firm, you will be liable for all costs which would be incurred as if the debt is collected in full, including legal demand costs.