Office use

MEDICAL HISTORY QUESTIONNAIRE
KRUGER VILLAGE DENTAL SURGERY

Dr/Mr/Mrs/Ms/Miss/Mst Last Name ____________________________ First Name ____________________________
(please circle)

Date of Birth _____/____/_____ Occupation ____________________________ Email Address ________________________________

Street Address ____ Suburb ______________________________ Post Code __________

Tel: Home _________________________ Mobile ____________________________________ Work _________________________

Contact in case of emergency _________________________ Relationship ___________________ Phone ______________________

Are you in a Private Health Fund? **Yes / No** If Yes, which one? ____

How did you find us? (please circle) Yellow Pages Yellow pages online Internet Search Local Paper
Health Fund Flyers Signage
Other dentist (name) _______________ School (name) ___________________________
Personal referral (name) ____

Do you feel nervous about your dental treatment? (No) **1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** (Extremely) **(please circle)**

Approximate date of your last dental check up / x-rays ____

Who is your usual GP? ______________________________ Suburb _________________________ Tel_______________________

Are you currently taking any medication, drugs or pills? **Yes / No**

If Yes, please list medication and dosages ____

____

(if not enough space available, please write on back of this form)

Are you allergic to any drugs, medicines or materials (e.g. Penicillin, Aspirin, Nurofen, Panadeine)? **Yes / No**

If Yes, please list ____

Do you normally require antibiotic cover before dental treatment? **Yes / No**

Are you currently undergoing medical treatment? **Yes / No**

Do you smoke? **Yes / No**

Ladies – Are you nursing? **Yes/No** Are you pregnant? **Yes / No / Maybe**

If Yes, when are you due? ____

Please indicate below if you have had, or have at present, any of the following **(please circle condition as well as Yes/No)**

High/Low Blood Pressure	**Yes/No**	Epilepsy	**Yes/No**	Artificial Joint (Hip, Knee)	**Yes/No**
Rheumatic Fever	**Yes/No**	Diabetes	**Yes/No**	Heart Complaint/Chest Pain	**Yes/No**
Steroid Therapy	**Yes/No**	Thyroid Disease	**Yes/No**	Heart Valve Disorder	**Yes/No**
Chemotherapy	**Yes/No**	Radiation Therapy	**Yes/No**	Congenital Heart Disease	**Yes/No**
Sinus Problems	**Yes/No**	Stroke	**Yes/No**	Artificial Valve	**Yes/No**
Cardiac Pacemaker	**Yes/No**	Hepatitis A, B or C	**Yes/No**	Mitral Valve Prolapse	**Yes/No**
Stomach Ulcers	**Yes/No**	Other Liver Disease	**Yes/No**	Heart Murmur/Surgery/Attack	**Yes/No**
Asthma/Hay Fever	**Yes/No**	Contact with HIV/AIDS	**Yes/No**	Bleeding Disorder eg. Haemophilia	**Yes/No**
Tuberculosis	**Yes/No**	Emphysema	**Yes/No**	Transplanted Organ or Marrow	**Yes/No**
Kidney Disease	**Yes/No**	Arthritis/Rheumatism	**Yes/No**		

I understand that all treatment is to be paid for on the day of treatment as no credit is given, and all information collected will be treated in confidence. **Yes / No**

If under 18, Parent/Guardian Name ____(**Parent must accompany to initial visit**)

Patient / Parent / Guardian Signature ____Date _____/_____/___
(please circle)