Dental ON MAHOE
TE AWAMUTU'S COMMUNITY & FAMILY DENTAL PRACTICE

CONFIDENTIAL PATIENT QUESTIONNAIRE

This provides the dentist with important information required for your Dental treatment and Oral Health Care.

Name: _____ Dr / Mr /Mrs / Miss / Ms
First Names Surname (Please select)

Date of Birth: _____
Home address: _____ Home phone: _____
_____ Mobile: _____
_____ Work phone: _____
Postcode: _____ Occupation: _____
Email address: _____

Emergency contact person:_____ Phone Number: _____

Doctor/Medical Centre: _____ Phone:_____

Medical History

1. Are you currently receiving any medical treatment ? **Yes/No**
   Details:_____
2. Are you taking any medicines, drugs, supplements or herbal remedies? If YES, please list. **Yes/No**
   Details:_____
3. Have you experienced any allergies or unusual effects from any medicines, tablets, drugs, injections, anaesthetic or latex? Details: _____ **Yes/No**
4. Have you ever had any of the following? If YES, please tick;

   - Anaemia ☐
   - Arthritis ☐
   - Asthma ☐
   - Bronchitis or chest issues ☐
   - Cold sores ☐
   - Depressive illness ☐
   - Diabetes ☐
   - Epilepsy ☐
   - Gastric issues ☐
   - Heart surgery ☐
   - High Blood Pressure ☐
   - Kidney issues ☐
   - Rheumatic Fever ☐
   - Severe headaches ☐
   - Stroke ☐

5. Have you ever been given or currently taking medication for cancer involving bone? **Yes/No**
6. Have you ever been given or are currently taking the drug Fosamax? **Yes/No**
7. Have you had any prosthetic surgery? (eg heart valve or hip replacement) **Yes/No**
   Details & Dates_____
8. Do you smoke or have you ever smoked? Details_____ **Yes/No**
9. Are you HIV positive? **Yes/No** Are you at risk of HIV exposure? **Yes/No**
10. Have you suffered from/do you suffer from Hepatitis? **Yes/No** Please Specify: **A, B, C** ☐☐☐
11. Women: Are you Pregnant? **Yes/No** If YES, Due Date: _____
12. Are there any other aspects concerning your health, that you think we should know about? **Yes/No**

Dental History

1. Name of last Dentist_____ Approximate date of last dental visit_____
2. Do you have Dental pain or a Dental problem at present?_____
3. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? **Yes/No**
4. Do you become anxious or uncomfortable when you are having dental treatment? **Yes/No**

How did you hear about us? _____

Sign: _____ **Date:**_____
Patient / legal guardian / representative
Relationship to Patient _____