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

CONFIDENTIAL YOUTH PATIENT QUESTIONNAIRE

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

Name: _____
First Names Surname

Date of Birth: _____

Home address: _____
_____
_____

Home phone: _____
Parent's Mobile: _____
Child's Mobile: _____

Postcode: _____ Email address: _____

Emergency contact person:_____ Phone: _____

Doctor/Medical Centre: _____ Phone: _____

Have you ever had any of the following?
If YES, please tick;

- Arthritis ☐
- Asthma ☐
- Anaemia ☐
- Bleeding disorders ☐
- Bronchitis ☐
- Chest pains ☐
- Cold sores ☐
- Depressive Illness ☐
- Drug dependence ☐
- Epilepsy ☐
- Gastric issues ☐
- Heart issues ☐
- High Blood Pressure ☐
- Kidney issues ☐
- Rheumatic fever ☐
- Severe headaches ☐
- Thyroid problem ☐
- Tuberculosis ☐

Please provide details:
_____
_____

Please CIRCLE your answer to the following questions;

Are you currently receiving any medical treatment? **Yes/No**
If YES, please list; _____
_____

Have you ever or are you currently taking any medicines, drugs, supplements or herbal remedies? **Yes/No**
If YES, please list; _____
_____

Have you experienced any allergies or unusual effects from any medicines, tablets, drugs, injections, anaesthetic or latex? **Yes/No**
If YES, please list
_____
_____

Do you have any artificial joints? **Yes/No**

Have you ever had contact with the HIV virus or Hepatitis A, B or C? **Yes/No**

Are you Pregnant? **Yes/No**
If YES, Due Date: _____

Do you smoke or have you ever smoked? **Yes/No**
If YES, please provide details; _____

Does your jaw 'click' or hurt? **Yes/No**

Do you feel you grind your teeth? **Yes/No**

Do you think you have occasional bad breath? **Yes/No**

Do your gums ever bleed when you clean your teeth? **Yes/No**

Are there any other aspects concerning your health that you think we should know about? **Yes/No**
If YES, please provide details;
_____
_____

Signed:_____
Patient/Parent/ Guardian (Please select)

Date: _____