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
Surname First Names (Please tick)

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

Emergency contact person:______________________ Phone Number:____________________
Medical Doctors Name: ______________________ Phone:____________________

Medical History

1. Are you receiving any medical treatment at the present time? **Yes/No**
   Details:____
2. Are You taking any medicines, tablets, capsules or drugs? If so please list. **Yes/No**
   Details:____
3. Have you experienced any allergies or unusual effects from any tablets, drugs, injections, Anaesthetic or latex? Details:______________________________ **Yes/No**
4. Have you ever had any of the following? If so please tick as appropriate

○ Rheumatic Fever	○ Epilepsy
○ Heart Surgery	○ Anaemia
○ High Blood Pressure	○ Diabetes
○ Stroke	○ Kidney Trouble
○ Arthritis	○ Gastric Problems
○ Hepatitis-Specify type A,B,C	○ Cold Sores
○ Bronchitis or Chest Problems	○ Depressive Illness
○ Asthma	○ Severe Headaches

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____
8. Women: Are you Pregnant? If So, how many months **Yes/No**
9. Are you HIV positive? **Yes/No** Are you at risk of HIV exposure? **Yes/No**
10. Do you Smoke **Yes/No**
11. 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: Patient to sign here or legal gaurdian or representative______________________ Relationship to Patient__________

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