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: _____ ☐ Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms
Surname First Names (Please tick)

Date of Birth: _____
Home address: _____
_____
_____
Postcode: _____
Email address: _____

Home phone: _____
Parent Mobile: _____
Childs Mobile: _____
Occupation: _____

Emergency contact person: _____ Phone Number: _____
Family Doctors Name: _____ Phone: _____

Please circle your answer to the following Questions

Are you Presently receiving any medical Treatment? Yes/No

Have you any allergies that you are aware of? Yes/No

Have you ever experienced excessive bleeding form dental treatment, cuts or scratches? Yes/No

Any Change in your general health in the past year? Yes/No

Please tick the box is you answer yes

Have you ever had any of the following?

- ☐ Rheumatic fever
- ☐ High Blood pressure
- ☐ Arthritis
- ☐ Bronchitis
- ☐ Severe headaches
- ☐ Epilepsy
- ☐ Gastric Problems
- ☐ Depressive Illness
- ☐ Tuberculosis
- ☐ Heart Trouble
- ☐ Asthma
- ☐ Hepatitis
- ☐ Chest pains
- ☐ Thyroid Problem
- ☐ Anaemia
- ☐ Kidney trouble
- ☐ Cold sores
- ☐ Drug dependence

Please Provide details:
_____
_____

Have you ever taken long term medications? Yes/No
_____

Have you any allergies to medicines? If yes please list Yes/No
_____

Have you any allergies to medicines? If yes please list Yes/No
_____

Do you have any artificial Joints? Eg hip joint Yes/No

Have you ever had contact with the AIDS virus or Hepatitis B virus? Yes/No

Have you ever had a reaction to an anaesthetic Yes/No

Are you Pregnant now? Yes/No
(if yes, Pregnancy due date)_____

Are there any other aspects concerning your health that you think we should know about? Yes/No
If yes Please indicate_____

Are you currently taking any drugs or medicines? Yes/No

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

Do you Smoke Yes/No

Additional information:
_____

Signed: _____
Patient/Parent/ Guardian