

FORUM DENTISTRY MEDICAL HISTORY QUESTIONNAIRE



FORUM DENTISTRY

Dear Patient, welcome to our office!

Please take your time to answer these questions as completely as possible.
It will assist us greatly in our effort to provide the best dental treatment for you.

PLEASE PRINT

Full Name: Mr/Mrs/Ms _____ Preferred Name: _____

Address: _____ Postcode: _____

City/Suburb: _____ Phone Home: _____

Occupation: _____ Date of Birth: _____ / _____ / _____
DAY MONTH YEAR

Employer: _____ Phone Work: _____

Nearest Relative (Not at your address): _____

Address: _____

_____ Phone Relative: _____

Person responsible for fees: _____

What dental insurance or benefit do you have? _____

When was your last dental treatment? _____

Who can we thank for referring you to our practice? _____

What is the purpose of today's visit? _____

Is there any dental problem in particular, that concerns you? _____

I don't experience any problems

Are there any dental cosmetic treatments you would like to discuss? Yes No

Whitening

Improved smile

Veneers

Crowns

Replace silver (amalgam) fillings

PLEASE TURN OVER

PLEASE TICK THE APPROPRIATE ALTERNATIVE ONLY

| | | |
|--|--------------------------|--------------------------|
| | YES | NO |
| Do you take drugs or prescribed medicine regularly? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any bad reaction to any treatment or medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any serious health problems during the past year? | <input type="checkbox"/> | <input type="checkbox"/> |

Do you suffer from any of the following?

| | PRESENT | PAST | NEVER |
|------------------------------|--------------------------|--------------------------|--------------------------|
| 1. Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Heart Disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Vascular Disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Blood Disease/Bleeder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Blood Pressure Problem | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Allergy/Hypersensitivity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Other Health Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

PLEASE GIVE FURTHER DETAILS OF MEDICATION AND ILLNESSES

Are you pregnant? No Yes _____ Months

How do you rate your general health? Perfect Good Fair Poor

Who is your doctor? _____

Telephone: _____

PLEASE TICK THE APPROPRIATE ALTERNATIVE ONLY

What problems do you have?

| | | | |
|-------------------------------|--------------------------|--|--------------------------|
| 1. Tooth ache | <input type="checkbox"/> | 9. Grinding/clenching of teeth | <input type="checkbox"/> |
| 2. Sensitive teeth (hot/cold) | <input type="checkbox"/> | 10. Worn/broken teeth | <input type="checkbox"/> |
| 3. Bleeding gums | <input type="checkbox"/> | 11. Pain in face or jaw joints | <input type="checkbox"/> |
| 4. Loosening teeth | <input type="checkbox"/> | 12. Sounds (clicking) from jaw | <input type="checkbox"/> |
| 5. Missing teeth | <input type="checkbox"/> | 13. Difficulty/discomfort when chewing | <input type="checkbox"/> |
| 6. Unsatisfactory denture | <input type="checkbox"/> | 14. Discoloured teeth (restorations) | <input type="checkbox"/> |
| 7. Rapidly decaying teeth | <input type="checkbox"/> | 15. Bad appearance | <input type="checkbox"/> |
| 8. Lost filling - cavity | <input type="checkbox"/> | 16. Other (Please give details) | <input type="checkbox"/> |

PLEASE REMEMBER WHAT YOU DID YESTERDAY TO CLEAN YOUR TEETH. PLEASE TICK

Yesterday I brushed my teeth Not at all Once Twice More than twice

Yesterday I flossed my teeth Not at all Once Twice More than twice

I used another cleaning aid Not at all Once Twice More than twice

What other aid did you use? _____

Do you feel you need happy gas for your dental treatment? Yes No

Do you want more information? Yes No

For dental treatment, do you prefer injections? Always Sometimes Never

Any problems with dental injections Yes No

Please give details: _____

Today's date: _____ Signature: _____