MEDICAL HISTORY QUESTIONNAIRE
IN CONFIDENCE.

Dr. P. Vuk & Dr. R. Bassi

SURNAME: _____

GIVEN NAME: _____

Please answer all the following questions, to enable us to provide dental care we require a sound knowledge of you general health.

DATE OF BIRTH: _____

ADDRESS: _____

SUBURB: _____

IF YOU ARE UNCERTAIN ABOUT ANY OF THE QUESTIONS PLEASE DISCUSS WITH YOUR DENTAL PRACTITIONER.

PHONE NUMBER: _____

MOBILE: _____

EMAIL: _____

QUESTION	CIRCLE YOUR ANSWER	QUESTION	CIRCLE YOUR ANSWER
1. Have you ever stayed in Hospital, had an operation or a general anaesthetic ?	YES/NO	12. Have you received human pituitary hormones prior to 1986 ?	YES/NO
2. Have either you or any member of the immediate family had a reaction of any nature to a general anaesthetic ?	YES/NO	13. Is the patient suffering from recent progressive dementia (of less han 12 months duration) the cause if which has not been diagnosed ?	YES/NO
3. Have you ever had any serious problems after dental treatment ?	YES/NO	14. Do you have a family history of two or more first degree relatives with Creuzfeild-Jacod Disease or other unspecified progressive neurological disorder ?	YES/NO
4. Have you ever had any type of - Heart disease - heart murmur - high blood pressure - Rheumatic Fever	YES/NO	15. Are you currently taking any medications or have taken any in the last 3 months. In particular, have you taken medications for osteoporosis, hypocalcaemia, Paget's Disease or other bone or calcium problems in the last 10 years ? (If YES, please list over page.)	YES/NO
5. Do you have a pacemaker ?	YES/NO	16. Have you ever had kidney problems	YES/NO
6. Have you ever had heart valve or open heart surgery ?	YES/NO	17. Do you have any joint problems, arthritis or history of joint replacement surgery ?	YES/NO
7. Have you ever had a stroke, fits or epilepsy ?	YES/NO	18. Are you pregnant ?	YES/NO
8. Have you ever had tuberculosis, asthma or any other lung disease ?	YES/NO	19. Do you have any other medical or disability problems ? (If YES, please list over page.)	YES/NO
9. Do you smoke ?	YES/NO	20. Do you have Diabetes ?	YES/NO
10. Have you ever hepatitis or any other liver disease ?	YES/NO	21. Are you allergic to any tablets, medicines, fruits or latex ? (if YES, please list over page.)	YES/NO
11. Have you had a dura mater graft or major neurosurgery between: 1972-1987 ?	YES/NO	22. Are you taking any Blood Thinners ?	YES/NO

Signature: _____ **Date:** _____

Who to contact in case of an Emergency ?

Name: _____

Phone: _____

Patient's Medical Doctor/
Name & Address: _____

_____

Current Medications:

Today's Date.	Drug.	Strength? (e.g. mg)	Number of times per day.	Times last taken.

MEDICAL PROBLEMS/OTHER PROBLEMS (please list below).

_____

_____

_____

_____

Clinician's signature: _____

Clinician's Name: _____

Medical History Reviewed:

Date: _____ Clinician's Signature: _____