Dr.JW

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ORAL SURGERY AND FACIAL REJUVENATION

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- 7 Whitehorse Rd, Deepdene 3103

- 27 Doncaster East Rd, Mitcham 3132 (Mitcham Private Hospital)
- 26 Balaclava Rd, St Kilda East 3183 (Masada Private Hospital)
- 343-357 Blackburn Rd, Mount Waverley 3149 (Waverley Private Hospital)

MEDICAL QUESTIONNAIRE

Welcome to the surgery.
Please take time to answer all questions as completely as possible. This will greatly assist us in providing the best treatment for you. All information will be treated with professional confidentiality.

PLEASE PRINT

FULL NAME Mr _____
Mrs _____
Ms _____
ADDRESS Home _____
_____ Postcode _____
POSTAL _____
ADDRESS _____ Postcode _____
TELEPHONE Home _____ Mobile _____
Work _____ Fax _____
EMAIL _____
DATE OF BIRTH ____/____/____

Occupation _____
Person responsible for fees _____
Next of kin Relation _____
(emergency) Address _____
Telephone No. _____

Who referred you to us? _____

Private dental cover/insurance details
Fund Name: _____ Policy Number: _____

Medicare details No: _____ Expiry date: _____

Medical Practitioner Name _____
Telephone No. _____

Dentist Name _____
Telephone No. _____

ALLERGIES
Are you allergic or have an adverse reaction to any medication or latex?

YES☐ NO☐ Details _____

_____

Do you suffer from the following? Please tick the correct response and provide details

Condition	Now	Previously	Details
Heart disease/Arrhythmia			
Heart murmur/congenital heart disease			
Heart surgery/valve replacement			
Rheumatic fever			
Pacemaker			
Stroke/mini stroke			
Blood clots/DVT/PE			
High blood pressure			
Blood disease/bleeding disorder			
Arthritis/Osteoporosis/Joint replacement			
Hepatitis A, B or C/ Carrier of Hepatitis			
HIV/AIDs			
Thyroid disorder			
Asthma/Bronchitis/Sinusitis/Lung disease			
Sleep apnoea			
Liver or Kidney disease			
Epilepsy/Seizures			
Fainting/Dizzy Spells			
Reflux/Stomach Ulcers			
Diabetes			
Cancer			
Radiotherapy/Chemotherapy			When? Site:
History of blood transfusion			
Use of intravenous drugs?			
Are you pregnant?			Weeks gestation:
Are you breastfeeding?			
Anxiety/Depression/psychiatric illness			
Smoking history			Year start? _____Year quit? _____ No. cig/day:
Alcohol intake			No. standard drinks/d
Other health problems?			

MEDICATIONS LIST: Please provide a detailed list of ALL prescription and non-prescription medications you are currently taking and the doses e.g. Aspirin 100mg 1 tablet once a day, Endep 25mg 1 tablet once a day, etc including herbal medicines such as St John's Wort, Ginko Biloba, etc.

Medication	Dosage	Medication	Dosage

Are you taking or have you taken **bisphosphonates** (eg. Fosamax, Aredia, Aclasta, Actonel, Didronel, Reclast, Pamisol, Skelid, Zometa) for:
☐Osteoporosis ☐ Paget's Disease ☐ Bone cancer, Cancer spread to bones ☐ Multiple myeloma ☐ Other

If previously taking **bisphosphonates**: When did you stop? _____; For how many years did you take them? _____

Please Turn Over

Do you suffer from any of the following jaw symptoms? (Please circle appropriate response)

Clicking jaw?	Yes	No	Sometimes	Right	Left	Both
Jaw locking open?	Yes	No	Sometimes	Right	Left	Both
Jaw locking shut?	Yes	No	Sometimes	Right	Left	Both
Grating or grinding jaw noises?	Yes	No	Sometimes	Right	Left	Both
Limited opening?	Yes	No	Sometimes			
Clench or grind your teeth whilst awake or asleep?	Yes	No	Sometimes			
Jaw pain?	Yes	No	Sometimes	Right	Left	Both

Other

Are you nervous of dental treatment? _____

What concerns you most? _____

When did you last have radiographs (x-rays) taken of your mouth? _____

Your Health Information

From time to time, I participate in educational lectures or research, which sometimes require treatment record details. All records such as x-rays and photos that are used are done so anonymously. If the need arises would you allow your treatment records to be utilised for this purpose?

Yes /No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any change in my health or medication.

Patient/Guardian Signature _____ Date _____