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Specialist Oral & Maxillofacial Surgeon

# Pre-consultation & Medical Questionnaire Form ver 0120

The information on this questionnaire is essential to provide you with the best professional care. We appreciate your co-operation in filling out this form carefully. **Please complete both sides of this questionnaire**. If you require assistance, please ask a staff member.

Title: _____ First Names(s): _____ Last Name: _____

Preferred Name: _____ DOB: _____ Age: _____ Gender: Male / Female

Residential Address: _____ Suburb: _____ Post Code: _____

Postal Address: _____ Suburb: _____ Post Code: _____

Email: _____ Occupation & Work Place: _____

Telephone: Home _____ Work _____ Mobile _____

Dental Practioner: _____ Address: _____

Medical Practioner: _____ Address: _____

**MEDICAL HISTORY:** Please tick the box of the following conditions which apply to you.

1. Are you presently receiving medical treatment? [ ]
2. Have you ever been admitted to hospital? [ ]
3. Do you or have you ever had any of the following?

| | | | |
|---|---|---|---|
| Rheumatic Fever | [ ] | Alcohol Dependence or Abuse | [ ] |
| Heart Trouble or Stroke | [ ] | Epilepsy | [ ] |
| High Blood Pressure | [ ] | Anaemia | [ ] |
| Asthma | [ ] | Bleeding Disorders | [ ] |
| Arthritis | [ ] | Tuberculosis | [ ] |
| Hepatitis A B C | [ ] | Gastric Problems | [ ] |
| Bronchitis/Chest Problems | [ ] | Cold Sores | [ ] |
| Migraine Headaches | [ ] | Mental or Depressive Illness | [ ] |
| Diabetes | [ ] | Kidney Trouble | [ ] |
| HIV/AIDS | [ ] | Drug Dependence | [ ] |
| Cancer/Malignancy/Neoplasm | [ ] | Osteoporosis/Bone Disease | [ ] |
| | | Other | [ ] |

4. Are you taking any tablets, medicines or drugs? [ ]

   If so please list: _____

   _____
5. **Are you allergic to any medications? Please list:**_____
6. Have you had joint replacement surgery e.g. prosthetic knee, hip etc? [ ]
7. Have you had any other previous surgery? If so, please specify _____
8. Have you ever experienced excessive bleeding or bruising from cuts, scratches or surgery? [ ]
9. Have you ever had contact with the hepatitis or AIDS/HIV virus? [ ]
10. Have you ever had a reaction to an anaesthetic? [ ]
11. Women: Are you pregnant at the moment? [ ] _____ weeks
12. Do you smoke cigarettes, cigars, tobacco? Yes [ ] No [ ] If yes, how many cigarettes per day? _____
13. How many standard drinks of alcohol per week do you have? *(1 can of beer or 1 glass of wine is 1.5 std drinks)*? _____
14. Can you easily walk up two flights of stairs without stopping? Yes [ ] No [ ]
15. Any family history of cancer (e.g. throat, tongue, mouth, neck, breast, prostate, bowel)? _____

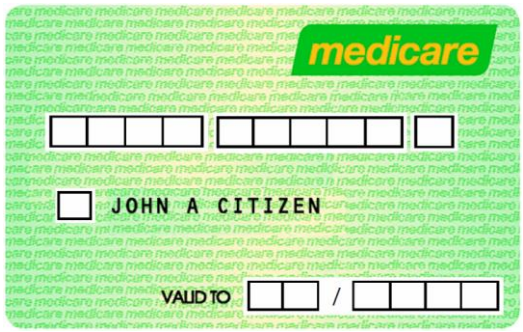
Is there anything else regarding your health that you think we should know about?

_____

**PLEASE TURN OVER**

**First Name: _____ Surname: _____**

**MEDICARE DETAILS:**




**INSURANCE DETAILS: (***reference number is the number in front of your name)*

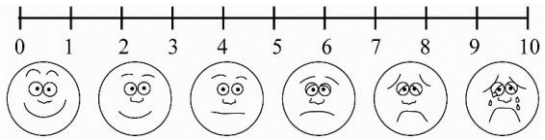
Do you have hospital cover / private health insurance? No [ ] Yes [ ] If so please provide details below:

Private Health Fund Name: _____ Number: _____ Reference No.: _____

**DVA CARD HOLDERS:** Gold [ ] White [ ] Number: _____

How would you rate your overall comfort with dental treatment? (please circle a number below)

*extremely comfortable* *extremely distressed*




Would you allow your treatment records to be utilised anonymously for teaching or education purposes? Yes [ ] No [ ]

How did you hear about us?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Referred by dentist | [ ] | Referred by doctor | [ ] | Google Search | [ ] | Word of mouth | [ ] |
| Health share | [ ] | Health Fund | [ ] | Private Hospital | [ ] | Other | [ ] |
| Camden Golf Club | [ ] | | | | | | |

**EMERGENCY CONTACT:**

First Name: _____ Last Name: _____

Mobile Number: _____ Relationship: _____

**DECLARATION:**

The medical history I have given is true and correct to my knowledge, and I have also disclosed all medications including over-the-counter and herbal remedies that I am taking.

I give permission for a copy of correspondence letters and test results to be sent to the GP I have indicated on this form.

Signature: _____ Date: _____

Name of parent or guardian for patients under 16 years: _____

**PRIVACY POLICY:**

This practice is committed to maintaining the privacy of your personal health information. Your medical record is a confidential document. It is the policy of this practice to maintain the security of your personal health information at all times. This practice will ensure that this information is only available to authorised members of staff or other health professionals as considered necessary in the context of your treatment.

We may also contact you or communicate with other clinicians via email for non-urgent, non-sensitive information. Please inform us if you would prefer to not receive emails.