azubelDENTAL
comprehensive dentistry

Welcome to our practice & thank you for choosing to entrust us with your dental care

To assist us in providing you with the best possible treatment and standard of care, we ask that you complete this confidential medical history questionnaire.

PERSONAL DETAILS

Full Name ______________________ Date of Birth ______________

Address ____

Phone Home ____________ Work ____________ Mobile ____________

Email Address ______________________________

What is your preference for communication from our practice? (please circle)

Home Phone Work Phone Mobile SMS Email

Occupation ____

Person responsible for account ____________________ Health Fund ______________

Emergency contact / relationship ______________________________

Who recommended you to us? ______________________________________

Name of your GP ______________________ Phone No ______________

Address ______________________________

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DENTAL HISTORY

What is the reason for your visit today? ____________________

Date of last dental visit ________ Last dental cleaning ________ Last full mouth x-rays ________

What was done at your last dental visit? ____________________

Previous dentist's name ____________________

Address ____________________ State ________ Postcode ________

How often do you have dental examinations? ____________________

How often do you brush your teeth? ________ How often do you floss? ________

What other aids do you use? ____________________

Do you have any dental problems now? Yes / No

If yes, please describe: ____________________

Are any of your teeth sensitive to:

Hot or Cold?	Yes / No
Sweets?	Yes / No
Biting or Chewing?	Yes / No
Have you noticed any mouth odours or bad taste?	Yes / No
Do you frequently get sores, blisters or other oral lesions?	Yes / No
Do your gums bleed or hurt	Yes / No
Have your parents experienced gum disease or tooth loss?	Yes / No

Do you:

Clench or grind your teeth while awake or asleep?	Yes / No
Bite your lips or cheeks regularly?	Yes / No
Hold foreign objects in your teeth? (pencils, pipe, pins, nails, fingernails)	Yes / No
Breathe through your mouth while awake or asleep?	Yes / No
Have tired jaws, especially in the morning?	Yes / No
Smoke? How many?	Yes / No
Would you like to keep all of your teeth all of your life?	Yes / No

Have you ever had:

Dental Implants?	Yes / No
Orthodontic Treatment?	Yes / No
Oral Surgery?	Yes / No
Periodontal or Gum Treatment?	Yes / No
A bite plate or mouthguard?	Yes / No
A serious injury to the mouth or head?	Yes / No
Any previous dental infections?	Yes / No

If so, please describe, including cause?

____

____

Have you experienced:

Clicking or popping of the jaw?	Yes / No
Pain (joint, ear, side of face)?	Yes / No
Difficulty in opening or closing the mouth?	Yes / No
Headaches, neck aches, or shoulder aches?	Yes / No
Sore muscles (neck, shoulders)?	Yes / No

Are you satisfied with your teeth's appearance: Yes / No

If not, please describe the issue or discomfort ____________________

Do you feel nervous about having dental treatment? Yes / No

Please describe ____________________

Have you ever had an upsetting dental experience? Yes / No

Please describe: ____________________

Is there anything else about having dental treatment that you would like us to know?

Please describe: ____________________

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MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? Yes / No

If yes, for what? ______________________________

Physician's Name ______________________ Phone ______________

Address ______________________ State ________ Postcode ________

Have you taken any medication or drugs during the past two years? Yes / No

Are you taking any medication, drugs or pills now? Yes / No

If yes, please list name and dosage ______________________________

Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes / No

If yes, please list ______________________________

Have you been a patient in the hospital during the past five years? Yes / No

Indicate which of the following you have had, or have at present **Circle 'yes' or 'no' to each item.**

Heart (surgery, disease, attack)	Yes / No	Stroke	Yes / No	Radiation Therapy	Yes / No
Chest Pain	Yes / No	Stomach Ulcers	Yes / No	Chemotherapy	Yes / No
Congenital Heart Disease	Yes / No	Diabetes	Yes / No	Cold Sores/Fever Blisters	Yes / No
Heart Murmur	Yes / No	Thyroid Problems	Yes / No	Haemophilia	Yes / No
High Blood Pressure	Yes / No	Glaucoma	Yes / No	Bruise easily	Yes / No
Mitral Valve Prolapse	Yes / No	Emphysema	Yes / No	Liver Disease	Yes / No
Artificial Heart Valve	Yes / No	Chronic Cough	Yes / No	Kidney Trouble	Yes / No
Heart Pacemaker	Yes / No	Tuberculosis	Yes / No	Neurological Disorders	Yes / No
Rheumatic Fever	Yes / No	Asthma	Yes / No	Epilepsy or Seizures	Yes / No
Arthritis/Rheumatism	Yes / No	Hay Fever	Yes / No	Fainting or Dizzy Spells	Yes / No
Cortisone Medicine	Yes / No	Latex Sensitivity	Yes / No	Nervous/Anxious	Yes / No
Swollen Ankles	Yes / No	Allergies or Hives	Yes / No	Artificial Joints (hip, knee, etc.)	Yes / No
Diet (Special/Restricted)	Yes / No	Sinus Troubles	Yes / No	Tumours	Yes / No

Do you have or have you had any disease, condition or problem not listed? Yes / No

If yes, please list ______________________________

Women - are you Pregnant? Yes / No Months________

Nursing Yes / No

Taking birth control pills? Yes / No

Do you think you may be pregnant? 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.

I hereby give my authority for any treatment agreed upon by me, to be carried out by Dr. Rodrigo Azubel and the staff at azubelDENTAL and assume full financial responsibility for said treatment

Patient/Guardian Signature ______________________ Date ______________