PATIENT PERSONAL & MEDICAL QUESTIONNAIRE

PRIVATE & CONFIDENTIAL

PRIVACY STATEMENT: We value your privacy. All of the information which you provide to us will be held and used by us in accordance with our Privacy Policy. A copy of our Privacy Policy is attached to this Questionnaire. Please take time to read through our Privacy Policy before answering the Questionnaire and speak to one of our staff members if you have any concerns about how we will use your personal information.

myEndodontist

Welcome to our Practice

Please answer these questions as completely as possible. It will greatly assist us to provide the best dental treatment for you.

Name
(Mr/Mrs/Miss/Ms/Dr/Other)……
(First Names) *(Family Name)*
Preferred name……..……..……Date of Birth……..……..……Gender……
Address……..……..……..……
Suburb……..Postcode.....
Phone (Home) ……..……Phone (Mobile)……..……Phone (Work)…..……..……
Email……..……Occupation……..……..……
Preferred Daytime Contact: Home/Work/Mobile/E-mail *(Please Circle)*
Emergency Contact…….……Relationship…..……...Phone…….....
Private Health Fund *(if applicable)* ……..……DVA Card number *(if applicable)*……..…..…..
Whom may we thank for referring you to our practice?…….....

The state of your health may have a significant effect on your dental care.
Please answer these questions fully or discuss them with your endodontist:

- I have a private and confidential medical matter which I wish to discuss with the endodontist Y / N
- Are you receiving any medical treatment at present? Y / N
- Name of your medical practitioner/specialist……..

Some medicines may interfere with your dental treatment or react with medications used by your dentist. It is important that your endodontist knows precisely what medications (if any) that you are taking.

Please list any medications you are currently taking, or have been taking recently, including injections, herbal remedies, vitamins, supplements, cold/flu treatments, sleeping pills, pain relievers, implants, so we can take appropriate precautions and avoid drug interactions.

Drug Name	Dosage	Duration	Purpose

Please list any known ALLERGIES, or ADVERSE REACTIONS to drugs (especially antibiotics e.g. penicillin), medicines, antiseptics, local anaesthetics, latex, preservatives that we should know about.

Drug Name	Nature of Reaction	How Long Ago

If you are in any doubt about your medication, please bring a **Pharmacy Medication Summary** or the bottle or packet(s) to the practice to show the endodontist.

….. please turn over

Please indicate YES or NO if you have <u>ever</u> had any of the following:

Have you or has anyone in your Household been advised to self-isolate?	Y / N	Have you been diagnosed or had close contact with someone diagnosed with COVID-19 in the past 14 days?	Y / N
Have you experienced or had close contact with anyone experiencing a sore throat, fever, cough or respiratory issues in the past 14 days?	Y / N	Have you returned from overseas or had close contact with anyone who has returned from overseas in the past 14 days?	Y / N
Heart condition – If yes, which condition?	Y / N	Asthma	Y / N
Heart valve problems or pacemaker	Y / N	Bleeding disorder	Y / N
Rheumatic fever	Y / N	Diabetes	Y / N
High Blood Pressure	Y / N	Epilepsy	Y / N
Jaw, neck, or shoulder injury or pain	Y / N	Anxiety/Depression	Y / N
Osteoporosis or low bone density – If yes: Are you taking any medication or receiving injections? e.g. Fosamax, Actonel, Prolia injections, etc	Y / N	Cancer or malignancy of any kind – If yes: Type of treatment: Radiation Chemotherapy Immunotherapy	Y / N
Kidney disease/transplant	Y / N	Hip or joint replacement – If yes: What year of replacement?	Y / N
Liver disease/transplant	Y / N	Hepatitis or carrier – If yes: What type?	Y / N
Is there any chance you are at risk of carrying HIV/AIDS?	Y / N	Do you carry any other infectious diseases? e.g. Herpes Simplex, CMV, Herpes Zoster If yes, what conditions & treatments?	Y / N
Do you smoke? If yes: How many per day How many years	Y / N	Do you drink alcohol?	Y / N
Have you ever used illicit substances and/or recreational drugs? If yes: When? Recent or More than 1 year ago?	Y / N		
Ladies Is there a possibility that you are pregnant? If yes, how many weeks? Note: Some medications may influence the effectiveness of hormonal contraception, please advise your endodontist if this is relevant in your case.			

Declaration:
In signing this form I acknowledge that this represents an accurate medical history.
I will advise my endodontist of any changes to my medical history in the future.
I understand that all medical details will be treated with complete professional confidentiality.
I have read the privacy document provided by this practice.

Patient signature……Date……
(Parent or guardian if under 18 years)

Reviewed by……Date……