MEDICAL HISTORY QUESTIONNAIRE

03 9380 1305
Brunswick Dental Group
266 Sydney Road
Brunswick, Melbourne
VIC 3056

Dear Patient, Welcome to our Office,
In order to render treatment of a high standard, it is necessary to have the following information, which will be handled confidentially.
Please fill it in as accurately as possible.

Thank you

PATIENT INFORMATION					
☐ Mr	☐ Mrs	☐ Miss	☐ Ms.		
Surname				Given Names	
Street address:					
Suburb:			State:		Post Code:
Home Phone		Work Phone		Mobile	

INSURANCE INFORMATION				
Health Fund :		Membership No.....		Series No.: .....
Are you a Veteran Affairs Card Holder?	☐ Yes	☐ No	Drivers Licence No.:	
Are you a Seniors Card Holder?	☐ Yes	☐ No	Card No.:	
Name of your Doctor/G.P.:.....				
How did you hear about this practice?				
☐ Family / Friend	☐ Local Paper	☐ Passing by	☐ Yellow Pages	☐ Other: .....

MEDICAL AND DENTAL HISTORY		
Have you ever had heart problems?	☐ Yes	☐ No
Have you ever had high blood pressure?	☐ Yes	☐ No
Have you ever had a blood transfusion?	☐ Yes	☐ No
Have you ever had Rheumatic Fever, Diabetes, Hyperthyroidism, Asthma, Glaucoma, Nervous Disorders, Anaemia, Arthritis?	☐ Yes	☐ No
Have you ever had any other serious illness?	☐ Yes	☐ No
Are you currently under medical treatment	☐ Yes	☐ No
Are you taking any drugs or medication?.....	☐ Yes	☐ No
Have you any known allergies to drugs (especially Penicillin) medicines, antiseptics, iodine?.....	☐ Yes	☐ No
Do you suffer from, or have any reason to suspect you may have Hepatitis, A.I.D.S., or any other infectious disease?	☐ Yes	☐ No
Have you ever experienced prolonged bleeding?	☐ Yes	☐ No
(Women) If pregnant, how many months?	☐ Yes	☐ No
Is there anything that we should know about that you would like to discuss privately and confidentially with the dentist?	☐ Yes	☐ No

Patient/Guardian signature *Date*