HEALTH QUESTIONNAIRE

Mr / Mrs / Miss / Ms/ Master/ Dr

Given Names: _____ Surname: _____

Address: _____ Postcode: _____

Email Address: _____

Date of Birth: _____ Age: _____ Height (cm): _____ Weight (Kg): _____

Occupation: _____ Employer: _____

Telephone No. (Home): _____ (Work): _____ (Mobile): _____

Referred by (Dentist/Doctor/Orthodontist/Specialist): _____

Reason for being referred: _____

Doctor's Name & Number: _____

Private Health Fund: _____ Medicare No: __ __ __ __ __ __ __ __ __ __ Ref No: __ Valid to: _____

Who will be responsible for the payment of the account? _____

Email Address – for Accounts & Contact: _____

Next of Kin name & Contact: _____

Have you ever had any of the following conditions? Please circle either Yes (when?) or No

Heart problems/Rheumatic fever..... Yes No

Chest complaints/Asthma..... Yes No

Bleeding Problems..... Yes No

Epilepsy..... Yes No

Diabetes..... Yes No

Covid-19 Vaccinated 1st & 2nd ..... Yes No

High Blood Pressure..... Yes No

Kidney Disease..... Yes No

Hepatitis..... Yes No

Do you smoke?..... Yes No

Are you pregnant?..... Yes No

Had Covid-19, Date:..... Yes No

Are you allergic to any tablets/medicines/sticking plaster/other? If Yes, please list below..... Yes No

_____

_____

Are you taking any tablets/medicines? If Yes, please list below..... Yes No

_____

_____

Have you ever had injections or tablets for osteoporosis?..... Yes No

If Yes, when was your last injection or tablets taken? _____

Have you ever had a general anaesthetic or operation in hospital? If Yes, list below..... Yes No

_____

Have you ever had radiotherapy to your face and/or jaw for cancer?..... Yes No

Do you have any other conditions or medical problems not mentioned? If Yes, list below..... Yes No

_____

Patient/Parent/Guardian Name (print): _____ Signature: _____

Date: _____