Hobart Orofacial Pain and Special Needs Clinic

Oral Surgery & Sedation Medical History Questionnaire

It is important that you take the time to complete **ALL** the following information prior to your appointment. Please **DO NOT** leave any section blank or unanswered even if you do not think the questions are relevant to your situation for which you are seeking treatment.

PLEASE BRING THE COMPLETED DOCUMENT TO YOUR APPOINTMENT

Date: _____/_____/_____	Private Health Insurance: Number: Medicare Number:		Male ☐ Female ☐
Given Names Dr / Mr / Mrs / Ms / Miss			Date of Birth: _____/_____/_____ dd mm yy
Surname		Occupation:	
Contact Details	Home Phone: ( )	Business Phone: ( )	
	Mobile Phone:	Email:	
	Address:		Postcode:

Please provide the following information in **FULL**:

GP's First/Surname:	Practice Name:	Practice Address (incl Post Code):	Phone number:
Dentist's First/Surname:	Practice Name:	Practice Address (incl Post Code):	Phone number:

GENERAL MEDICAL HISTORY

Have you had in the past 10 years or do you currently have any of the following conditions?

Please tick either 'Yes' or 'No'	Yes	No	Please tick either 'Yes' or 'No'	Yes	No
Anaphylaxis……..			Heart Palpations / Arrhythmias…		
Angina……			Heart Surgery……		
Anxiety / Depression……			Heart Valve Replacement……		
Asthma……			Hepatitis A / B / C……..		
Bleeding Disorder……			HIV / AIDS……		
Blood Pressure High / Low……			Insomnia……		
Blood Thinning Treatment……			Irritable Bowel Syndrome……		
Bruise Easily……..			Kidney Disease……		
Cancer……			Liver Jaundice		
Chemotherapy……			Lung Disease……		
Chronic Fatigue……			Nose Surgery……		
Cirrhosis of the Liver……			Osteoarthritis……		
Congestive Heart Failure……			Osteoporosis……..		
Deep Vein Thrombosis……			Radiation Therapy……		
Diabetes IDDM / NIDDM……			Reflux……		
Drug Dependency……..			Rheumatic Fever……		
Elevated Cholesterol……..			Rheumatoid Arthritis……		
Emphysema……..			Sinus Surgery……..		

Please tick either 'Yes' or 'No'	Yes	No	Please tick either 'Yes' or 'No'	Yes	No
Endocarditis……..			Smoker 0-10 / 10-20 / >20 per day		
Epilepsy……..			Snoring / Sleep Apnoea		
Gastric / Peptic Ulcer……..			Stroke / Mini Stroke……..		
Hashimoto's Disease……..			Thrombocytopenia……		
Haemophilia……			Thyroid Problems……		
Heart Attack……..			Tonsils Removed……		
Heart Murmur……			Von Willebrand's Disease……..		
Heart Pacemaker……			Wisdom Teeth Extractions……..		

Have you had lap band surgery?	**Yes**	**No**
Have you had previous anaesthetic in hospital or sedation? If yes, did you experience any complications? Please describe:	**Yes** **Yes**	**No** **No**
Recreational and illicit drugs can have serious adverse reactions to anaesthetics - Have you used in the past any drugs recreationally? If yes, please list types and quantities (or years used):	**Yes**	**No**
Do you consume alcohol? If yes, please list quantity per day or week	**Yes**	**No**
Do you have a history of snoring or obstructive sleep apnoea?	**Yes**	**No**
Do you suffer from any jaw joint problems such as pain, clicking, grating/grinding noises, locking, or stiffness?	**Yes**	**No**

Medications List: Please provide a detailed list of ALL prescription and non-prescription medications you are currently takin and the doses e.g. Aspirin 100mg 1 tablet once a day, Endep 25mg 1 tablet once a day, etc including herbal medicines such as St John's Wort, Ginko Biloba, etc.

Medication	Dosage	Month / Year Started

ALLERGIES: Please list any allergies or adverse drug reactions you may have had:_____

_____

Please Read and Sign Patient Declaration

- I declare that the information provided by me contained in this Sedation MHQ is, to the best of my knowledge, correct and accurate.
- I agree to pay all costs associated with any debt recovery that may occur in my name for any treatmentment that commences and remains as an outstanding account.
- I have read and understand this declaration.

Name_____ **Signature**_____ **Date**_____/_____/_____

Dr Tony Eldridge **Signature** **Date**_____/_____/_____

MEDICAL – DENTAL
--Confidential--