ORAL & MAXILLOFACIAL SURGERY OF WA

FRANC R. C. HENZE
MD, DMD, BScDent (Hons), FRACDS, FRACDS (OMS)
GradCertAviationMed, Justice of the Peace

PATIENT QUESTIONNAIRE

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

☐ Mr ☐ Mrs
☐ Ms ☐ Miss
☐ Dr ☐ Other

First name ____________ Last name ____________

Address

Date of birth / /

Phone numbers
Home Work Mobile

Email

Person responsible for payment of this account

Medicare/DVA # Ref #

Private health insurance Memb #

Hospital cover ☐ Y ☐ N Dental cover ☐ Y ☐ N

MEDICAL QUESTIONNAIRE - PRIVATE AND CONFIDENTIAL

The state of your health may have a very significant effect on your dental care. Please answer these questions fully or discuss them with Dr Henze or his nurse.

Do you have private and confidential medical matters you wish to discuss? ☐ Y ☐ N

Are you receiving any medical treatment at present? ☐ Y ☐ N

Nave you ever been in hospital? ☐ Y ☐ N

Name of referring doctor / dentist

Do you smoke? ☐ Y ☐ N If yes, for how long?

What do you smoke (cigarettes, cigars, pipe, other)? How much do you smoke?

Have you ever required treatment for any smoking-related diseases or conditions? ☐ Y ☐ N

Females

Are you pregnant? ☐ Y ☐ N If so, when are you due? / /

Are you breastfeeding? ☐ Y ☐ N

MEDICAL QUESTIONNAIRE - CONTD.

Some medications may interfere with your dental treatment or react with medicaments used by your doctor. It is important that Dr Henze knows precisely what medications (if any) you are taking. Please provide details (including dose and frequency) of any medication you are currently taking.

	Medication	Details
	Aspirin	
	Warfarin, clopidogrel, heparin or newer generation blood thinning medications	
	Treatment for osteoporosis (bisphosphonates) orally or via injection	
	Cortisone or steroids	
	Oral contraceptive	
	Hormone replacement therapy	
	Medication for depression (MAOIs or tricyclics)	
	Antiepileptics	
	Other	

Please indicate if you have ever had any of the following.

	Any heart (cardiac) complaint		High or low blood pressure		Cardiac pacemaker
	Asthma/bronchitis/ lung conditions		Excessive bruising or bleeding		Epilepsy (fits)
	Heart valve replacement/stents		Osteoporosis or low bone density		Diabetes
	Gastroesophageal reflux disease		Thyroid disease (including goitre)		Radiation therapy
	Hepatitis, jaundice or liver disease		Treatment for any form of cancer		Rheumatic fever
	Joint replacement surgery		Any nervous system disorder		Jaw joint problems
	Transplanted organ or bone marrow		Tuberculosis (TB)		

Allergies   Please specify:

Please indicate if you suffer from any illness not listed above (e.g. hepititis B or C, HIV) or add any other comments

Declaration: In signing this form I acknowledge that this represents an accurate medical history. I will advise the doctor of any changes to my medical history in the future. I understand that all medical details will be treated with complete professional confidentiality.

Patient signature (or parent/ guardian if under 18 years)   Date   /   /