THE PERIODONTISTS CONFIDENTIAL QUESTIONNAIRE

To ensure we provide the best possible care, please complete the following (using BLACK or BLUE pen)

Title: Surname:	First Name:
Date of Birth:	Preferred Name:
Address:	Occupation:
Home Ph:	Mobile Ph:
Work Ph:	**APPOINTMENT reminders?** ❍ **EMAIL** ❍ **SMS**
Email:	
Emergency Contact & Relationship:	Ph:
Name of your Dr/Medical GP:	Ph:
DVA Membership Number:	
Health Fund & Member No.:	
Medicare No.:	

Do any of the following apply to you?

Do your gums bleed when you brush or floss your teeth?	❍ Yes	Do you have a bad taste in your mouth or bad breath?	❍ Yes
Do you have any missing teeth you would like to replace?	❍ Yes	Do you have any gaps in your teeth which catch food?	❍ Yes
Do you feel nervous/anxious about dental treatment?	❍ Yes	Have you noticed any lumps/bumps/ulcers in your mouth?	❍ Yes
Do you think you grind your teeth?	❍ Yes	Does your jaw click or hurt?	❍ Yes
Do you experience any gum pain?	❍ Yes	Do you have any loose teeth?	❍ Yes
Do you have any gum recession/shrinkage?	❍ Yes	Do you experience sensitivity with hot/cold?	❍ Yes
Would you prefer to have your periodontal treatment with intravenous sedation or a general anesthetic?	❍ Yes		

Previous Dental History

Who is your general dentist? _____

If not your general dentist, who referred you to Dr Samy Francis? _____

How long since your last general dental appointment? _____

Have you had periodontal treatment before? _____

Are you happy for you & your dental/medical professionals to receive correspondence by email from The Periodontists? ❍ Yes ❍ No

PTO…

What concerns do you have about dental treatment?

- ○ Fear
- ○ Pain
- ○ Other, please list:
- ○ Cost
- ○ Time Constraints

Please list: _____

MEDICATION AND RECREATIONAL DRUG SPECIFICS & HISTORY

To ensure we provide the best possible care, please complete the following (using BLACK or BLUE pen)

Medication Name	Dose Taken (eg 50mg twice a day)	Duration of Use (eg 2 years, 5 months)	Purpose

DO YOU or HAVE YOU EVER taken medications for Osteoporosis and/or Chemotherapy?

○ **Yes** ○ **No** **If yes, please specify in the table above**

MEDICATION DECLARATION:
In signing this form I acknowledge this represents an accurate medication history. I will advise my dentist of any changes to my medical history in the future. I understand all medical details will be treated with complete professional confidentiality. I have read The Periodontists privacy policy document.

Patient: _____ Date: _____

Parent / Responsible Party's signature: _____ Date: _____

Relationship to patient: _____

PTO...

SEE* 'MEDICAL QUESTIONNAIRE' *BELOW, IF YOU'RE AN EXISTING PATIENT AND HAVE HAD NO CHANGES PLEASE TICK HERE ❍

Have you had or have any of the following, please indicate appropriately?

Allergies to medications If yes, what? _____	❍ Yes	Heart problems If yes, what? _____	❍ Yes
Anaemia or other blood clotting disorders	❍ Yes	Heart valve replacement	❍ Yes
Anaesthetic sensitivity GA / LA / IV	❍ Yes	Hepatitis A / B / C	❍ Yes
Antibiotic required prior to dental treatment	❍ Yes	HIV/AIDS	❍ Yes
Anxiety / depression	❍ Yes	Joint replacement surgery If yes, what & date _____	❍ Yes
Asthma / bronchitis / lung conditions	❍ Yes	Liver or kidney problems	❍ Yes
Blood pressure HIGH / LOW	❍ Yes	Neck, jaw or shoulder damage/pain	❍ Yes
Cancer If yes, what type & treatment _____	❍ Yes	Osteoporosis	❍ Yes
Diabetes	❍ Yes	Rheumatic fever	❍ Yes
Diabetes – family history	❍ Yes	Sinus trouble	❍ Yes
Epilepsy / neurological conditions	❍ Yes	Stomach ulcers	❍ Yes
Excessive bleeding	❍ Yes	Are you pregnant or breastfeeding Due date? _____	❍ Yes
Excessive bruising	❍ Yes		

Any operations/illnesses not listed? _____

Do you vape/smoke, if so, how often/many per day? _____

Do you have a previous history of vaping/smoking? ❍ Yes ❍ No Approx date quit? _____

Do you drink alcohol, if so how many units per day? _____

Is there anything else we have not covered please advise? _____

TO BE COMPLETED BY NEW PATIENTS ONLY

How did you hear about us?

- ❍ Yellow Pages: ❍ *BOOK* ❍ *ONLINE*
- ❍ Internet: ❍ *GOOGLE* ❍ *OTHER*
- ❍ Not a Patient
- ❍ Dentist/Specialist
- ❍ Walk/Drive Past
- ❍ The Periodontists Website
- ❍ Existing Patient

If 'Other' at 'Internet', which search engine? _____

If 'Existing Patient' or 'Not a Patient', who recommended you? _____

CONFIDENTIAL QUESTIONNAIRE DECLARATION:
In signing this form I acknowledge this represents an accurate medical history. I will advise my dentist of any changes to my medical history in the future. I understand all medical details will be treated with complete professional confidentiality. I have read The Periodontists privacy policy document.

Patient: _____ Date: _____

Parent / Responsible Party's signature: _____ Date: _____

Relationship to patient: _____