



Medical History Questionnaire

Dr Patrick O'Rourke and the team welcome you to Riverside Dental. To assist us in providing you with the best possible treatment and standard of care, we ask that you complete this confidential medical history questionnaire.

Title Dr / Mr / Mrs / Miss / Ms

First Name: _____ Surname: _____ Date Of Birth: ___/___/___

Home address: _____ Postcode: _____

Postal address: _____ Postcode: _____

Phone (H): _____ Phone (M): _____

Phone (W): _____ Workplace / Occupation: _____

Email: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Who may we thank for referring you to Riverside Dental? : _____

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This form is designed to alert us of any medical conditions that may interfere with the comfort or safety of your dental care. We will ensure that this information will remain private and confidential. Please ask for assistance if required.

| | | | |
|------------------------------------------|-----|----|-----------------------|
| Do you have any illness at present? | YES | NO | Please specify: _____ |
| Are you currently taking any medication? | YES | NO | Please specify: _____ |
| Do you have any allergies? | YES | NO | Please specify: _____ |
| Women, are you pregnant? | YES | NO | If yes, due on? _____ |
| Have you ever smoked? | YES | NO | If yes, When?: _____ |

Have you ever suffered from: (Please circle all that apply)

- | | | |
|----------------------|------------------------|-----------------------------------|
| -High Blood Pressure | -Hepatitis B/C | -Asthma |
| -Heart Disease | -Diabetes | -Cancer Therapy |
| -Heart Murmur | -Epilepsy | -Bleeding/Blood clotting Disorder |
| -Rheumatic Fever | -Contact with HIV/AIDS | -Dizzy spells |
| -Thyroid disease | -Hay fever | Other: _____ |

Do you require Antibiotic cover for dental treatment? _____

Have you had any Surgical Procedures in the last two years? _____

Family Medical Doctor: _____ Do you have Private Health Cover? _____

Signature (Patient / Guardian) : _____

Date ___/___/___

Please turn over.

Dental History Questionnaire

I routinely see my dentist every: 3mth 4mth 6mth 12mth only when I have a problem

How would you rate the condition of your mouth: Poor Fair Good Excellent

WHAT IS YOUR IMMEDIATE CONCERN? _____

Many people still feel nervous about going to see their Dentist. We aim to provide you with a friendly and relaxed environment and take extra measures to ensure your comfort. Please circle the number that indicates how you are feeling at the moment.

Completely at ease 0 1 2 3 4 5 6 7 8 9 10 Petrified

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES

NO

PERSONAL HISTORY



1. Have you had an unfavorable dental experience? _____
2. Have you ever had complications from past dental treatment? _____
3. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____
4. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____
5. Have you had any teeth removed? _____

SMILE CHARACTERISTICS



6. Is there anything about the appearance of your teeth that you would like to change? _____
7. Have you ever whitened (bleached) your teeth? _____
8. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____
9. Have you been disappointed with the appearance of previous dental work? _____

BITE AND JAW JOINT



10. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
11. Do you / would you have any problems chewing gum? _____
12. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____
14. Are your teeth crowding or developing spaces? _____
15. Do you have more than one bite and squeeze to make your teeth fit together? _____
16. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
17. Do you clench your teeth in the daytime or make them sore? _____
18. Do you have any problems with sleep or wake up with an awareness of your teeth? _____
19. Do you wear or have you ever worn a bite appliance? _____

TOOTH STRUCTURE



20. Have you had any cavities within the past 3 years? _____
21. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____
22. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____
23. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth _____
24. Do you have grooves or notches on your teeth near the gum line? _____
25. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
26. Do you frequently get food caught between any teeth? _____

GUM AND BONE



27. Do your gums bleed or are they painful when brushing or flossing? _____
28. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
29. Have you ever noticed an unpleasant taste or odor in your mouth? _____
30. Is there anyone with a history of periodontal disease in your family? _____
31. Have you ever experienced gum recession? _____
32. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
33. Have you experienced a burning sensation in your mouth? _____

Patient's Signature: _____ Date: _____

Doctor's Signature _____ Date: _____