

# St Leonards **holistic** dental care

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Dr Charlotte de Courcey-Bayley

## MEDICAL HISTORY QUESTIONNAIRE

Charlotte de Courcey-Bayley and her team would like to welcome you to St Leonards Holistic Dental Care. 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.

### Personal Details

**Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone Home** \_\_\_\_\_ **Work** \_\_\_\_\_ **Mobile** \_\_\_\_\_

**Email Address** \_\_\_\_\_

**What is your preference for communication from our practice? (please circle)**

Home      Phone Work      Phone Mobile      SMS      Email

**Occupation** \_\_\_\_\_

**Who recommended you to us?** \_\_\_\_\_

From time to time our dentist participates in educational lectures or research, which sometimes requires treatment records of their clients. All records such as x-rays and photo's that are used are done so anonymously. If the need arises would you allow your treatment records to be utilised for this purpose?

**Yes /No**

# DENTAL HISTORY

## What is the reason for your visit today?

Date of last dental visit \_\_\_\_\_ Last dental cleaning \_\_\_\_\_ Last full mouth x-rays \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous dentist's name \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

What other aids do you use? \_\_\_\_\_

Do you have any dental problems now? Yes / No

If yes, please describe \_\_\_\_\_

## Are any of your teeth sensitive to:

Hot or Cold? YES/NO

Sweets? YES/NO

Biting or Chewing? YES/NO

Being ground or having the bite adjusted? YES/NO

Have you noticed any mouth odours or bad taste? YES/NO

Do you frequently get sores, blisters or any other oral lesions? YES/NO

## Do your gums bleed or hurt?

Have your parents experienced gum disease or tooth loss? YES/NO

Have you noticed any loose teeth or change in your bite? YES/NO

Does food tend to become caught between your teeth? YES/NO

If yes, where? \_\_\_\_\_

## Do you:

Clench or grind your teeth while awake or asleep? YES/NO

Bite your lips or cheeks regularly? YES/NO

Hold foreign objects in your teeth?  
(pencils, pipe, pins, nails, fingernails) YES/NO

Breathe through your mouth while awake or asleep? YES/NO

Have tired jaws, especially in the morning? YES/NO

## Are you satisfied with your teeth's appearance?

Would you like to change the colour of your teeth? YES/NO

Would you like to keep all of your teeth all of your life? YES/NO

Do you feel nervous about having dental treatment? YES/NO

If so, what is your biggest concern? \_\_\_\_\_

Have you ever had an upsetting dental experience? YES/NO

If yes, please describe

Is there anything else about having dental treatment that you would like us to know? \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

## Have you ever had:

Dental Implants? YES/NO

Orthodontic Treatment? YES/NO

Oral Surgery? YES/NO

Periodontal or Gum Treatment? YES/NO

A bite plate or mouthguard? YES/NO

A serious injury to the mouth or head? YES/NO

Any previous problems with dental infections? YES/NO

If so, please describe, including cause? \_\_\_\_\_

## Have you experience:

Clicking or popping of the jaw? YES/NO

Pain (joint, ear, side of face)? YES/NO

Difficulty in opening or closing the mouth? YES/NO

Difficulty in chewing or closing the mouth? YES/NO

Headaches, neck aches, or shoulder aches? YES/NO

Sore muscles (neck, shoulders)? YES/NO

# MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? \_\_\_\_\_ Yes No

If yes, for what? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

Have you taken any medication or drugs during the past two years? \_\_\_\_\_ Yes No

Are you taking any medication, drugs or pills now? \_\_\_\_\_ Yes No

If yes, please list name and dosage: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you aware of having an allergic (or adverse) reaction to any medication or substance? \_\_\_\_\_ Yes No

If yes, please list \_\_\_\_\_

Have you been a patient in the hospital during the past five years? \_\_\_\_\_ Yes No

Indicate which of the following you have had, or have at present. Circle 'yes' or 'no' to each item.

Heart (surgery, disease, attack)	Yes No	Stomach Ulcers	Yes No	Cold Sores/Fever Blisters	Yes No
Chest Pain	Yes No	Diabetes	Yes No	Haemophilia	Yes No
Congenital Heart Disease	Yes No	Thyroid Problems	Yes No	Bruise easily	Yes No
Heart Murmur	Yes No	Glaucoma	Yes No	Liver Disease	Yes No
High Blood Pressure	Yes No	Emphysema	Yes No	Kidney Trouble	Yes No
Mitral Valve Prolapse	Yes No	Chronic Cough	Yes No	Neurological Disorders	Yes No
Artificial Heart Valve	Yes No	Tuberculosis	Yes No	Epilepsy or Seizures	Yes No
Heart Pacemaker	Yes No	Asthma	Yes No	Fainting or Dizzy Spells	Yes No
Rheumatic Fever	Yes No	Hay Fever	Yes No	Nervous/Anxious	Yes No
Arthritis/Rheumatism	Yes No	Latex Sensitivity	Yes No	Artificial Joints (hip, knee, etc.)	Yes No
Cortisone Medicine	Yes No	Allergies or Hives	Yes No		
Swollen Ankles	Yes No	Sinus Troubles	Yes No	Tumours	Yes No
Stroke	Yes No	Radiation Therapy	Yes No	Do you smoke	Yes No
Diet (Special/Restricted)	Yes No	Chemotherapy	Yes No		

Do you have or have you had any disease, condition or problem not listed \_\_\_\_\_ Yes No

If yes, please list \_\_\_\_\_

Women- are you: Pregnant? Yes \_\_\_\_\_ Months No

Nursing Yes No

Taking birth control pills? Yes No

Do you think you may be pregnant? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any change in my health or medication.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## FOOD FREQUENCY

Indicate which foods and drinks are consumed and mark the frequency. Your dentist will fill out comments.

FOOD/DRINKS TYPES	HOW OFTEN	COMMENTS
WATER	Daily Occasionally Never/Rarely	
MILK PLAIN OR FLAVOURED	Daily Occasionally Never/Rarely	
CHEESE	Daily Occasionally Never/Rarely	
CHEWING GUM ORDINARY SUGAR FREE	Daily Occasionally Never/Rarely	
TEA/COFFEE WITH MILK WITH SUGAR ARTIFICIAL SWEETENER	Daily Occasionally Never/Rarely	
ICE CREAM	Daily Occasionally Never/Rarely	
CHOCOLATE	Daily Occasionally Never/Rarely	
CAKES, MUFFINS, PASTRIES, SWEET BISCUITS	Daily Occasionally Never/Rarely	
BREAD, CRACKER BISCUITS, WITH SAVOURY TOPPINGS WITH JAM/SWEET TOPPINGS	Daily Occasionally Never/Rarely	
DRIED FRUITS (SULTANAS, DATES, RAISINS, ETC)	Daily Occasionally Never/Rarely	
MUESLI TYPE BARS AND OTHER HEALTH BARS	Daily Occasionally Never/Rarely	
FIZZY/SPORTS DRINKS ORDINARY LOW CALORIE	Daily Occasionally Never/Rarely	
FRUIT JUICE	Daily Occasionally Never/Rarely	
CORDIALS	Daily Occasionally Never/Rarely	
YOGHURT	Daily Occasionally Never/Rarely	
LOLLIES, MINTS, JELLIES	Daily Occasionally Never/Rarely	
CITRUS FRUITS, GREEN APPLES	Daily Occasionally Never/Rarely	
VITAMIN C TABLETS	Daily Occasionally Never/Rarely	
COUGH LOZENGES	Daily Occasionally Never/Rarely	