Health Questionnaire

Personal Details

Surname: _____ Title (Mr, Mrs, etc): _____
First Names: _____
Preferred Name: _____ Spouse/Parent Name: _____
Date of Birth: _____ Occupation: _____
Postal Address: _____
Town: _____ Post Code: _____

Contact Details

Home: _____
Work: _____
Mobile: _____
Email: _____

Method of contact:
☐ Phone call
☐ SMS
☐ Email

Dental Insurance Company: _____
Veteran Affairs Number: _____

Medical History

Please answer Yes or No to any of the following conditions, if Yes, provide details:

CARDIOVASCULAR

Rheumatic Fever	☐ Yes	☐ No	_____	**CHRONIC HEADACHES**	☐ Yes	☐ No	_____
Heart murmurs or other defects	☐ Yes	☐ No	_____	**EPILEPSY**	☐ Yes	☐ No	_____
Heart surgery	☐ Yes	☐ No	_____	**RESPIRATORY**			
Endocarditis (heart infection)	☐ Yes	☐ No	_____	Asthma	☐ Yes	☐ No	_____
Cardiac Pacemaker	☐ Yes	☐ No	_____	Sinus/Hayfever	☐ Yes	☐ No	_____
Angina or Heart Attack	☐ Yes	☐ No	_____	**RADIATION THERAPY**	☐ Yes	☐ No	_____
Stroke	☐ Yes	☐ No	_____	**CHEMOTHERAPY**	☐ Yes	☐ No	_____
High/Low Blood Pressure	☐ Yes	☐ No	_____	**KIDNEY/LIVER DISEASE**	☐ Yes	☐ No	_____
INFECTIOUS DISEASES				**ARTHRITIS**	☐ Yes	☐ No	_____
HIV/AIDS	☐ Yes	☐ No	_____	**THYROID PROBLEMS**	☐ Yes	☐ No	_____
Herpes/Cold Sores	☐ Yes	☐ No	_____	**CHOLESTEROL**	☐ Yes	☐ No	_____
Hepatitis	☐ Yes	☐ No	_____	**BLEEDING DISORDERS**	☐ Yes	☐ No	_____
Other	☐ Yes	☐ No	_____	**JOINT REPLACEMENTS**	☐ Yes	☐ No	_____
DIABETES	☐ Yes	☐ No	_____	**OSTEOPOROSIS**	☐ Yes	☐ No	_____

MEDICATIONS

Do you have any allergies/reactions to any drugs/medicines? ☐ Yes ☐ No If yes, please list

_____

Do you have any other medical conditions you should alert us to? ☐ Yes ☐ No If yes, please specify

_____

What medications are you currently taking?

_____

_____

Do you have a regular Doctor/Medical Practice?	☐ Yes	☐ No	_____
Do you receive injections or take medication to manage osteoporosis?	☐ Yes	☐ No	_____
Do you regularly smoke cigarettes?	☐ Yes	☐ No	_____
Are you possibly pregnant or currently breastfeeding?	☐ Yes	☐ No	_____

Signature: _____ **Date:** _____

Please email this form to admin@oarandhoran.com.au or print and bring with you to your appointment.
Sign and date form on arrival at surgery. Thank you.