Patient's Details

Title: (eg: mr/mrs/miss)	Family Name:		
Date of birth:	Given Name:		
Home address:		Postcode:	
Postal address:		Postcode:	
Ph (hm):	Ph (wk):	Mob:	
Email address:			
Are you happy to receive email and/or SMS notification	Yes		No
Emergency contact details:		Ph:	
Parent / Guardian details (required if patient is under the age of 18)			
Family Name:	Given Name:		
Home Address:		Postcode:	
Ph (Hm):	Ph (wk):		
Mob:	Email:		
Other Family member that are patients of Woollahra Dental?			
Name:	Date of Birth:		
Name:	Date of Birth:		
Name:	Date of Birth:		

Referral Information

Who referred you to this practice?

_____

Medical History

Name of GP:	GP's contact number:
GP practice name:	

Are you, or do you suspect you may be, pregnant?	
Do you smoke?	
Do you suffer from Sleep apoea?	
Do you suffer from snoring?	
Is your blood pressure normal, high or low?	
Are you currently taking medication for osteoporosis?	
Have you had any serious illnesses in the last 2 years?	*If yes, please provide more information.*

Are you currently taking any medications or tablets regularly?	If yes, please provide more information.
Do you have any allergies (e.g. drugs, medication, dairy)	

Have you ever had any of the following? Please tick those that apply?

Anaemia		Fainting		pacemaker	
Arthritis		Glaucoma		Radiation therapy	
Asthma		Heart Disease		Respiratory problems	
Blood disease		Heart Murmur		Rheumatic fever	
cancer		Hepatitis A.B.C		Sinus problems	
dizziness		High blood pressure		stroke	
epilepsy		Kidney disease		Tuberculosis	
Excessive bleeding		Liver disease		Tumours	
Diabetes		HIV/AIDS		Psychological disorders	
Other (please list)					

Dental History

Are you concerned or experiencing any of the following dental problems? (Please tick as many as it applies)

Sensitivity to hot or cold		Food trapping between teeth	
Staining of your teeth		Grinding or clenching your teeth	
Bleeding gums		Clicking/pain in the jaw	
Roughness of existing fillings		Head/neck pain	
Bad breath		Sensitivity when eating	
Discoloured fillings		Other:	

How long since your last dental visit?

_____

Does dental treatment make you nervous? No ☐ Slightly ☐ Moderately ☐ Extremely ☐

What is the main purpose for you visit today?

_____

_____

_____

Please proceed to pain questionnaire:

Pain and TMJ

Operations, Accidents or Trauma

In the past have you ever had any of the following?

Any serious accidents such as motor vehicle	Yes	No
Any whiplash injuries	Yes	No
Any broken bones	Yes	No
Any severe blows to the head or jaw	Yes	No
Concussion or sudden loss of consciousness	Yes	No
Removal of tonsils, adenoids or appendix	Yes	No

Please give details

_____

_____

Pain Symptoms

In the past have you ever had any of the following?

Headaches	Yes	No
Neck aches or stiff neck muscles	Yes	No
Shoulder or back pain	Yes	No
Earaches	Yes	No
Jaw aches when chewing or opening wide	Yes	No
Removal of tonsils, adenoids or appendix	Yes	No

Please give details

How often are these pains felt and how long do they last

_____

_____

What can make the pain worse, or when does the pain get worse

_____

_____

When can make the pain better, or when is the pain better

_____

_____

What medication is taken for the pain and how often is it taken

_____

_____

Jaw and Joint Symptoms

In the past have you ever had any of the following?

'Clicking'. 'Popping', or 'Cracking' noise from jaw joints	Yes	No
A lock jaw so it could not be opened or closed	Yes	No
A tired jaw after eating a big meal	Yes	No
Difficulty opening the mouth wide or yawning	Yes	No
Pain in either jaw	Yes	No

Please give details

_____

_____

Ear and Eye Symptoms

In the past have you ever had any of the following?

Itchiness or stuffiness in either ear	Yes	No
Any loss of hearing	Yes	No
Any pain in, around or behind the ear	Yes	No
'Ringing', 'buzzing' or' hissing' sounds form either ear	Yes	No
Grating noises (like sand particles rubbing) in either ear	Yes	No

Please give details

_____

_____

Breathing Symptoms

In the past have you ever had any of the following?

Allergies	Yes	No
Sinus problems	Yes	No
Persistent blocked nose	Yes	No
Frequent colds sore throat and tonsillitis	Yes	No
Mouth breathing habit	Yes	No
Snoring during sleeping	Yes	No
Obstructive sleep apnoea (OSA)	Yes	No

Please give details

_____

_____

Dental Symptoms

In the past have you ever had any of the following?

Thumb or finger sucking habit	Yes	No

Speech problems or lisp	Yes	No
Various orthodontic treatment	Yes	No
Decay, missing or filled teeth	Yes	No
Bad Breath (halitososis)	Yes	No
Gum problems (bleeding or puffiness)	Yes	No

Please give details

_____

_____

Facial Pain and TMJ History

1. What is the Nature of your pain problem (Headache / Earaches / Neck aches etc)

_____

_____

2. Describe your disorder

_____

_____

3. When did you first notice you had a problem or pain

_____

_____

4. List the names of the health professionals that you have seen for treatment

_____

_____

5. In your opinion, were any of these treatments effective and how long for

_____

_____

6. List all the medications you are now taking, or have taken for this problem

_____

_____

6. List any medications you are now taking and what they were prescribed for

_____

_____

7. Have you had any X-rays taken of your jaw joints in another office or institution

Yes No.

If yes, we request you contact them and have them emailed/sent to our surgery at:

admin@woollahradental.com

Consent for Service

- I, the undersigned, consent to the performance of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated, and I will assume responsibility for the fees associated with those procedures.
- I hereby consent to the use of any study models, x-rays, computer images and photographs at various dental seminars, lectures, and publications that the dentists may author.
- I am aware that payment is required on the day of treatment and assume full financial responsibility I understand that the practice requires as minimum 24 hours' notice if I need to cancel my scheduled appointment and that a cancellation fee of $55.00 could be incurred if I fail to do so.
- I have accurately completed this preclinical examination questionnaire to the best of my knowledge. I hereby authorise Dr. Ancell and his staff to render any treatment agreed upon.

X_____ _____

Patient Signature **Date of signature**

Read and reviewed by: **Dr Anthony Ancell**

_____ _____

Signature **Date of signature**