



dr angelo lazaris

dentistry
cosmetic and general

Medical History Questionnaire

Dr Lazaris and his staff would like to welcome you to their practice.

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

Dr Angelo Lazaris B.D.S. Hons (Syd Uni)

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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

Have you noticed any mouth odours or bad taste? Yes / No

Bring ground or the bite adjusted? 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

Smoke/chew tobacco? 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 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

Your teeth ground or the bite adjusted? 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 experienced:

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



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History Review (OFFICE USE ONLY)

Dentist Signature _____ Date _____