ASLEEP DENTAL PTY LTD

Title_____First Name_____Surname_____

Date of Birth _____/_____/_____ **Health Fund_____**

Address _____P-Code_____

Phone Home (___)_____ Mobile_____

Phone Work _____ Employer _____

E-mail address _____

GP's Name and Clinic _____

Parent/Guardian Name/s (If Under 18)_____

How did you hear about our practice? *(please circle)*

Phonebook Radio Newspaper Previous Patient Family Friend

Other _____ If referred, by whom?_____

How would you like your appointment confirmed? *(please circle)*

Phone call SMS Email None

1. Are you being treated for any medical conditions? If so, what are they?

   _____

2. Are you currently taking any medications including **birth control, non-prescription drugs or herbal supplements including Ginkgo Biloba, Garlic, Ginseng, St John's Wort, Ephedra, Kava, and Echinacea ,Fish Oil?**

If yes, please list:_____

3. Have you been hospitalised in the last 2yrs? Yes / no

If yes, what for? _____

4. Do you have any allergies to medication/egg/soy/latex?_____
5. Any reactions to Nurofen, Naprosyn, Voltaren or any NSAIDS? _____
6. Do you bleed excessively when cut or bruise easily?_____
7. Are you currently taking or have taken cortisone / steroids?_____
8. Do you smoke or use other forms of tobacco? _____
9. Do you suffer from Needle Phobia or other Anxiety issues?_____
10. Do you snore or have sleep problems?_____
11. *WOMEN ONLY* are you / do you suspect you may be pregnant? _____
12. *MALE ONLY* Are you taking any male enhancement drugs? ie Viagra/ Cialis_____

Do you have or have you ever had ***(Please circle)***

Asthma / Bronchitis / COPD	Yes	No
Arthritis	Yes	No
Artificial Joints *(Hip, Knee)*	Yes	No
Angina / Chest Pains	Yes	No
Cancer now or in the past	Yes	No
Diabetes	Yes	No
Epilepsy / Seizures	Yes	No
Heart Murmur	Yes	No
Heart Surgery	Yes	No
Contact with or do you have Hep B/C HIV	Yes	No
High Blood Pressure	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Radiation Treatment to head or neck for cancer	Yes	No
Recipient of human pituitary hormones *(Growth Hormones / Gonadotrophins)*	Yes	No
Rheumatic Fever/Scarlet Fever	Yes	No
Shortness of breath on exertion	Yes	No
Stroke	Yes	No
Gastrointestinal ulcers	Yes	No
Thyroid condition	Yes	No
Drug / Alcohol Dependency now or in the past	Yes	No
Osteoporosis or Paget's Disease	Yes	No
Any False/loose/broken/damaged capped teeth?	Yes	No
Do you wear Dentures?	Yes	No

13. Have you had any other serious illness, if so please state: _____
14. When was your last dental check-up?_____
15. What is the purpose of your visit today?_____
16. Do you have a particular concern? *(e.g. Sensitive Teeth/Bleeding Gums)*_____
17. Are you happy with the appearance of your teeth? _____
18. Do you use any recreational drugs like marijuana, ice, cocaine, heroin, ecstasy NMDA, etc.____
19. Are you on Methadone or Naltrexone?_____
20. Do you wish to discuss anything privately with the dentist?_____

_____ _____ _____

Signature *(Patient / Guardian)* **Date** **Dentist**

DOCTORS USE ONLY

1. Have there been any changes in your weight or appetite?
Yes No

2. Have you been excessively tired from doing the things that you would normally do, i.e.: walking stairs, doing housework, and performing your normal work functions
Yes No

3. Has there been any change in your tolerance to either heat or cold?
Yes No

4. Are there any significant features to your medical history that we have not touched on thus far?

_____
_____
_____
_____

5. Can you climb 2 flights of stairs without stopping?
6. Can you breathe properly when you lie flat?
7. Do you have a family history of malignant hyperthermia?

Have you ever had surgery? If yes List
_____
_____
_____
_____
_____

ANY PROBLEMS WITH PAST GENERAL ANESTHETICS OR SEDATIONS
_____
_____

DOCTORS USE ONLY

ASA STATUS 1 2 3 4 5
AIRWAY STATUS 1 2 3 4

Physical

Lungs _____

Heart _____

BP _____ Pulse _____

Sa02_____

Weight in KG _____Height in Cm_____BMI_____

Lab Tests required Preop _____

Significant findings

_____
_____
_____
_____
_____
_____
_____
_____

CHIEF COMPLAINT

_____
_____
_____
_____