

DR JACLYN WONG

MBBS, BDS (Hons), PG Dip Surp Anat

ORAL SURGERY AND
FACIAL REJUVENATION



Medical Questionnaire

Please Print

Welcome to the surgery. Please take time to answer all questions as completely as possible. This will greatly assist us in providing the best treatment for you. All information will be treated with professional confidentiality.

Patient Details

Full Name Mr Ms Mrs Dr Prof

Home Address

Post Code

Postal Address

Post Code

Telephone

Home

Mobile

Work

Fax

Email

DOB

Occupation

Person Responsible for Fees

Next of Kin (Emergency)

Name

Relation

Address

Phone

Who referred you to us?

Private dental cover / Insurance Details

Fund Name

Policy Number

Medicare No

Expiry Date

Medical Practitioner

Telephone

Dentist

Telephone

Allergies

Yes No

Details

Please turn over

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LOCATIONS:

175 Riversdale Rd, Hawthorn, VIC 3122

26 Balaclava Rd, St Kilda East 3183 (Masada Private Hospital)

343-357 Blackburn Rd, Mount Waverley 3149 (Waverley Private Hospital)

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Do you suffer from any of the following?

Please tick the correct response and provide details

Heart disease/Arrhythmia	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Heart murmur/congenital heart disease	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Heart surgery/valve replacement	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Rheumatic fever	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Pacemaker	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Stroke/mini stroke	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Blood clots/DVT/PE	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
High blood pressure	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Blood disease/bleeding disorder	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Arthritis/Osteoporosis/Joint replacement	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Hepatitis A, B or C/ Carrier of Hepatitis	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
HIV/AIDs	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Thyroid disorder	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Asthma/Bronchitis/Sinusitis/Lung disease	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Sleep apnoea	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Liver or Kidney disease	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Epilepsy/Seizures	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Fainting/Dizzy Spells	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Reflux/Stomach Ulcers	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Diabetes	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Cancer	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Radiotherapy/Chemotherapy	<input type="radio"/>	Now	<input type="radio"/>	Previously	When?		Site?	
History of blood transfusion	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Use of intravenous drugs?	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Are you pregnant?	<input type="radio"/>	Now	<input type="radio"/>	Previously	Weeks gestation			
Are you breastfeeding?	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Anxiety/Depression/psychiatric illness	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Smoking history	<input type="radio"/>	Now	<input type="radio"/>	Previously	Year start:		Year quit:	Amount/day:
Alcohol intake	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			
Other health problems?	<input type="radio"/>	Now	<input type="radio"/>	Previously	Details			Please turn over

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Medication List

Please provide a detailed list of ALL prescription and non-prescription medications you are currently taking and the doses e.g. Aspirin 100mg 1 tablet once a day, Endep 25mg 1 tablet once a day, etc including herbal medicines such as St John's Wort, Ginko Biloba, etc.

Medication	Dosage	Medication	Dosage

Are you taking or have you taken bisphosphonates (eg. Fosamax, Aredia, Aclasta, Actonel, Didronel, Reclast, Pamisol, Skelid, Zometa) for:

Osteoporosis Paget's Disease Bone cancer, Cancer spread to bones Multiple myeloma Other

If previously taking bisphosphonates: When did you stop?

For how many years did you take them?

Do you suffer from any of the following jaw symptoms? Please tick the correct response and provide details

Clicking jaw Yes No Sometimes Right Left Both

Jaw locking open Yes No Sometimes Right Left Both

Jaw locking shut Yes No Sometimes Right Left Both

Grating or grinding jaw noises Yes No Sometimes Right Left Both

Limited opening Yes No Sometimes

Clench or grind your teeth whilst awake or asleep? Yes No Sometimes

Jaw pain Yes No Sometimes Right Left Both

Other

Are you nervous of dental treatment?

What concerns you most?

When did you last have radiographs (x-rays) taken of your mouth?

Your Health Information

From time to time, I participate in educational lectures or research, which sometimes require treatment record details. All records such as x-rays and photos 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

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.

Parent/Guardian Signature

Date

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