DR JACLYN WONG

MBBS, BDSc (Hons)

Postgraduate Diploma Surg Anat

ABN: 22 840 177 197

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

Please turn over

DEN0001598621 | MED0001206369

Melbourne Oral Surgery & Facial Rejuvenation

Ground Floor, 3/1601 Malvern Road, Glen Iris VIC 3146

T: +61 3 9078 2485 | 0422 944 830

E: info@drjaclynwong.com.au

W: drjaclynwong.com.au

@drjaclynwong

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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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