

## ADULT PATIENT HEALTH QUESTIONNAIRE

Please answer all of the following questions and bring this form with you when you attend your consultation.  
Thank you

Patients Name: \_\_\_\_\_  
(First name) (Surname)

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Postal Code: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email address: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Who were you referred by (Dentist/Friend): \_\_\_\_\_

Name of your Dentist: \_\_\_\_\_

Person/s Responsible for all Accounts: \_\_\_\_\_

Billing address (if different from above): \_\_\_\_\_

Name of General Doctor: \_\_\_\_\_

Specialist: \_\_\_\_\_ illness being treated: \_\_\_\_\_

What (if any) serious illnesses have you had in the past: \_\_\_\_\_

List any medications being taken at present: \_\_\_\_\_

Have you had any allergies or sensitivities to: Penicillin: Yes/No

Other medications:(List) \_\_\_\_\_

Latex: Yes/No Nickel: Yes/No

Have you ever had Heart Valve Disease/ Rheumatic Fever/ Heart Murmur: Yes/No: \_\_\_\_\_

Have you ever had chest trouble, asthma or TB: Yes/No: \_\_\_\_\_

Do you get short of breath, have high blood pressure or heart trouble: Yes/No: \_\_\_\_\_

Have you ever had abnormal bleeding or bruising: Yes/No: \_\_\_\_\_

Have you ever had jaundice or hepatitis: Yes/No: \_\_\_\_\_

Have there ever been any significant illnesses within your immediate family: Yes/No: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_