HUNTER ORAL & MAXILLOFACIAL
Surgery Centre

Dr Ian R. Wilson - Provider No: 509547H
BDS (Syd), MDS FRACDS, FRACD (OMS),
Grad Dip Arts (Theology), Cert IV (Counselling)

Prof. Dr Gary R. Hoffman - Provider No: 2271286T
MBBS, MMedSc, MD, PhD, FACS, FRCS (Irel),
FRCS (Glasg), FRCS (Eng), BDSc, MDSc, FRACDS, FACOMS

Dr Benjamin Gupta - Provider No: 5358992B
BDS, MFDS, Dip Con Sed, BMed, FRACDS (OMS)

Medical Questionnaire

Patient Name _____ Date of Birth _____

- Your answers will help our surgeons provide you with the most appropriate treatment
- The information you give is strictly confidential
- Your honesty may assist in avoiding health problems

Tick Appropriate Box

1. **Have you ever suffered from any of the following?** ☐ Yes ☐ No
   If yes, please tick where appropriate
   ❑ Heart disease ❑ High blood pressure ❑ Rheumatic fever ❑ Asthma ❑ Diabetes
   ❑ Kidney disease ❑ Hepatitis ❑ Epilepsy ❑ Anaemia ❑ Osteoporosis
   ❑ Other prolonged illness, please give details _____

2. **Do you have any allergies to any medications or substances?** ☐ Yes ☐ No
   If yes, please tick where appropriate
   ❑ Penicillin ❑ Pain killers ❑ Iodine ❑ Anti-inflammatories ❑ Codeine ❑ Latex
   ❑ Other medication/drug/substance, please give details _____
   Reaction: ❑ Rash ❑ Swelling ❑ Vomiting ❑ Other, give details _____

3. **Have you had any operations?** ☐ Yes ☐ No
   If yes, please list (including year)
   _____
   _____

4. **Have you or your family had any problems with general anaesthesia?** ☐ Yes ☐ No
   If yes, what problems did you experience? _____

5. **Have you ever had prolonged bleeding following tooth extraction, cut or injury?** ☐ Yes ☐ No

6. **Are you currently under any long term medical treatment?** ☐ Yes ☐ No
   If yes, please give details _____

7. **Do you take any of the following Medications?** ☐ Yes ☐ No
   If yes, please tick where appropriate
   ❑ Warfarin ❑ Aspirin ❑ Plavix ❑ Any other blood thinning medication

8. **Are you taking any medications or drugs regularly?** ☐ Yes ☐ No
   If yes, name/list medications or drugs _____

9. **Do you use recreational drugs? (E.g. cannabis, cocaine, heroin)** ☐ Yes ☐ No

10. **Do you consume alcohol?** ☐ Yes ☐ No
    If yes, how many glasses per day? ❑ 0-5 ❑ 5-10 ❑ 10 or more

11. **Do you smoke?** ☐ Yes ☐ No
    If yes, how many per day? ❑ < 10 ❑ 20-30 ❑ 30-60 ❑ More

12. **If female, might you be pregnant?** ☐ Yes ☐ No

13. **Are there any other health issues you wish to discuss with your surgeon?** ☐ Yes ☐ No

14. **Is there anything your surgeon should be aware of that is not on this form?** ☐ Yes ☐ No
    If yes, please give details _____

Signature _____ Date _____

Name in full _____

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Practice Privacy Policy

We respect your privacy

In order to provide you with the highest standard of oral surgery care, this Practice is required to collect personal information from you. This information covers basic details such as your name, address and telephone number but it is also necessary to obtain from you details regarding your general health and past medical or surgical events. Without this general health picture, the treating Practitioner is unable to plan your care properly.

Naturally, some of this information is of a personal nature and some of it might be regarded as "sensitive" and not the sort of information that you wish to be unnecessarily disclosed to others.

We value the need to safeguard this information and, in accordance with the principles laid down in privacy legislation and the guidelines issued by the Australian Dental Association, we would like to assure you that:

- This information will only be issued by the treating Practitioner in order to deliver your care to the highest standards.
- It will not be disclosed to those not associated with your treatment, without your express consent.
- You may seek access to the information held about you and we will provide this access without undue delay. This access might be by inspection of your records at the time of your appointment or by special access or copying of information.
- There will be no charge for requesting this information but there may be fees levied just to cover the costs associated with the processing of this request for copying information.
- We will take all reasonable steps to ensure at all times that the details we keep about you are accurate, complete and up-to-date.
- We will take all reasonable steps to protect this information from misuse or loss and from unauthorised access, modification or disclosure.
- Our staff are trained to respect these principles at all times.

If you have any questions regarding the information we collect from you and hold in your records at this Practice, please do not hesitate to ask us. We are acting in your interests at all times.

Patient consent to provide information

I, _____ _____ _____

PRINT NAME SIGNATURE DATE

Hereby give consent for Dr Ian Wilson/Dr Gary Hoffman/Dr Benjamin Gupta to obtain and release relevant information regarding my clinical history.

THIS DOCUMENT WILL BE HELD IN YOUR FILE