

MEDICAL – DENTAL

--Confidential--

Elevated Cholesterol.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Smoker 0-10 / 10-20 / >20 per day	<input type="checkbox"/>	<input type="checkbox"/>
Endocarditis.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke / Mini Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Swollen, stiff, or painful joints.....	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Thirst.....	<input type="checkbox"/>	<input type="checkbox"/>	Thrombocytopenia.....	<input type="checkbox"/>	<input type="checkbox"/>
Gastric / Peptic Ulcer.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Hashimoto's Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils Removed.....	<input type="checkbox"/>	<input type="checkbox"/>
Haemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	Trigeminal Neuralgia.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Von Willebrand's Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Wisdom Teeth Extractions.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>			
Other – Please list any medical conditions not included above					

Medications 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	Month / Year Started

ALLERGIES: Please list any allergies you may have including food and medications:

Do you suffer from any of the following jaw symptoms? *(Please circle appropriate response)*

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			
Jaw pain?	Yes	No	Sometimes	Right	Left	Both

PATIENT DECLARATION:

I declare that the information provided by me in the Oral Surgery MHQ is, to the best of my knowledge, correct and accurate.

Name: _____ Signature: _____ Date: ____/____/____