MEDICAL/DENTAL HISTORY FORM

It is important to know details about your medical history as these could affect the success of your dental treatment and how we can provide this treatment safely for you. The information you provide is confidential and will be handled in accordance with our privacy policy which is available upon request.

Title *(eg Mr/Mrs/Ms):* | Last Name:

Date of birth: | First name(s):

Home address: Postcode:

How did you find out about our practice?

Ph (hm): Ph (wk): Mob: Email:

Name of other family in attendance of our practice: Their Phone No:

I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this *(Please tick box).* ❑

	No	Yes
Do you normally require antibiotic cover before dental treatment?		
Have you had any abnormal reactions to local or general anaesthesia?		
Do you smoke?		
Are you pregnant? *(Females only)*		
Are you being treated by a doctor at present?		
Are you taking any prescription or other medications at present?		
Have you been hospitalised in the last 12 months?		
Have you or anyone in your household returned from overseas travel in the last 10 days?		

List Medications:

Please list current medications:

Who is your medical practitioner: Medicare Number:

Please list any drugs or medicines you are allergic to:

Please list any other known allergies (including latex, foods and preservatives):

DO YOU HAVE NOW, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS?
Please tick either yes or no for each condition

	No	Yes		No	Yes		No	Yes
Steroid therapy			Kidney disease			Prosthetic implant eg artificial hip		
Rheumatic fever			Excessive bleeding			Cardiac pacemaker		
Epilepsy			Stroke			Stomach or digestive condition		
Asthma			Cancer			Hepatitis or other liver diseases		
Diabetes			Thyroid disease			Contact with blood-borne viruses		
Heart disorder/complaint			Snoring/ Sleep Apnoea			Bronchitis, emphysema or other lung diseases		
Bone disease, including osteoporosis			Anxiety/ Depression			Anemia, leukemia or other blood diseases		
Radiation therapy			High or low blood pressure			Any other conditions		

Any other condition(s) not mentioned *(please list):*

PLEASE LIST ANY CONCERNS OR PROBLEMS THAT YOU HAVE WITH YOUR TEETH OR MOUTH:

Do you belong to a health fund? Yes No If so, which one?

Your / Guardian's signature: Date:

OFFICE USE ONLY Reviewed by: (please print name) Signature: Date: