

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | | | | | | | | List Medications: | | | |
| 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? | | | | | |  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| 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 Rheumatic fever Epilepsy Asthma Diabetes Heart disorder/complaint  Bone disease, including osteoporosis  Radiation therapy |  |  | Kidney disease Excessive bleeding Stroke  Cancer  Thyroid disease  Snoring/ Sleep Apnoea  Anxiety/ Depression  High or low blood pressure |  |  | Prosthetic implant eg artificial hip Cardiac pacemaker Stomach or digestive condition Hepatitis or other liver diseases Contact with blood-borne viruses  Bronchitis, emphysema or other lung diseases  Anemia, leukemia or other blood diseases  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: | | | | | | | | | | | |