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 treated in accordance with our privacy policy.

(Mr/Mrs/Miss/Ms/Dr) ___________ Surname: ___________________________

Date of Birth: ___ / ___/____ First Name: ___________________________

Home Address: ___________________________ Postcode: ___________

Postal Address: ___________________________ Postcode: ___________

Home Ph: _______________ Work Ph:_______________ Mobile:_______________

Healthfund:_______________ Email: ___________________________

How would you like us to contact you. Home Ph ☐ Work Ph ☐ Mobile (SMS) ☐ Email ☐

Where did you hear about us: ___________________________

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?			
Are you being treated by a Doctor at present?			
Are you taking any prescription or other medication 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?			

Who is your medical practitioner?	Ph:
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 or circle appropriate answer

	No	Yes		No	Yes		No	Yes
AIDS/HIV			Anaemia, leukaemia or other blood disorders			Arthritis		
Asthma			Bleeding problems			Blood Pressure High / Low		
Bronchitis, emphysema or other lung diseases			Cancer			Cardiac pacemaker		
Contact with blood-borne viruses			Diabetes			Epilepsy		
Excessive Bleeding			Excessive Bruising			Glaucoma		
Heart disorder/complaint			Hepatitis or other liver diseases			Nervous or psychiatric condition / Depression		
Stroke/CVA			Radiation Therapy			Rheumatic fever		
Sinus problems			Steroid Therapy			Stomach / digestive condition		
Prosthetic implant eg. artificial hip			Thyroid disease			Tuberculosis		

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

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

I have read and accept the privacy policy display in reception (copy is available)

Your / Guardian's signature: ___________________________ Date: ____/____/2017