MEDICAL HISTORY FORM

Title: Mr, Master, Mrs, Miss, Ms, Dr, Prof.

Surname: ________________________________ First Name: ______________________________________

DOB: ______/_____/_____ Email: ____

Address:____Suburb:_____________________

Ph: (H) ______________________ (W) ___________________ (M) ________________________________

Dental Insurance: HCF/AHM/BUPA/NIB Other: ________________ Occupation: ___________________________

Are you being treated by a Doctor at present? Yes / No

Are you taking any medications? Yes / No

Please list all Medication / Tablets____

Have you been a hospital patient in the last five years? Yes / No

Has your Medical Practitioner recommended antibiotic cover before dental treatment? Yes / No

Who is your General Practitioner? ____

Please list any drugs/materials you are allergic to ____

PAST MEDICAL HISTORY: Please tick all that apply

☐ Rheumatic Fever
☐ Epilepsy
☐ Asthma
☐ Diabetes
☐ HIV/AIDS virus
☐ Kidney disease
☐ Excessive bleeding
☐ Heart Complaint
☐ High Blood pressure
☐ Smoker
☐ Anaemia
☐ Tuberculosis
☐ Hepatitis A B C
☐ Seizures
☐ Thyroid condition
☐ Nervous condition
☐ Stroke
☐ Prosthetic Implant
☐ Heart Valve Disorder
☐ Cardiac Pacemaker
☐ Latex Allergy

Other: ____

Ladies are you or might you be pregnant Yes / No Due Date? _______________________

Please list any previous problems you have experienced with dental treatment?

____

Emergency Contact:_______________________Relationship:__________________Ph:___________________

Are your happy with your smile? YES NO What would you like to change_________________________

Have your ever whitened your teeth? YES NO Would you like to? YES NO

Is there anything specific you would like to discuss with the dentist? NO YES________________________

Signature: ______________________________________Date: _________________________________

Parent/Guardian Name: ___________________________________