MEDICAL HISTORY FORM

Dr/Mr/Mrs/Ms/Miss

Patient's Name
(please print)

Address

Suburb

State Postcode

Sex ☐ Male ☐ Female

D.O.B Phone H

Mobile Email

Emergency Contact

Emergency Relation & Mobile

Patient's Occupation

Are you in a health fund? ☐ Yes ☐ No

Do you hold a Veterans Affairs Gold Card? ☐ Yes ☐ No

Card Number & Expiry

Are you under the care of any other dental specialist? ☐ Yes ☐ No

Have you ever been treated here before? ☐ Yes ☐ No

If so, when?

1. General Health

☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. Are you under the care of a doctor for any medical conditions?

☐ Yes ☐ No

If yes, please explain

3. Name and address of family doctor

4. Are you wearing a pacemaker or heart valve prosthesis or do you have a joint replacement or any other medical implant?

☐ Yes ☐ No

If yes, please explain

5. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?

☐ Yes ☐ No

If yes, please explain

6. Are you taking any kind of medication (prescribed or non-prescribed) or drug at this time?

☐ Yes ☐ No

If yes, please explain

7. Have you been diagnosed as having HIV, AIDS (Acquired Immune Defi-ciency) or ARC (Aids Related Complex)?

☐ Yes ☐ No

8. Are you pregnant?

☐ Yes ☐ Months ☐ No ☐ N/A

9. Have you ever undergone endodontic/root canal treatment?

☐ Yes ☐ No

Circle any of the following to which you are allergic or have had an unusual reaction to.

Penicillin	Aspirin	Nitrous Oxide	Sulpha Drugs
Codeine	Steroids	Erythromycin	Valium
Sedatives	Ibuprofen	Latex/Rubber	Flagyl

Other

10. Do you have a history of any of the following disorders?

Lung Disease	Blood Disorders	Anaemia	Stomach Ulcer/Reflux
Sinus Trouble	Thyroid Trouble	Asthma	Fainting Spells
Heart Trouble	Herpes	Heart Attack	Chronic Bronchitis/Cough
Hay Fever	Arthritis	Heart Murmur	Shortness of Breath
Kidney Trouble	Convulsions	Diabetes	Rheumatic Fever
Tuberculosis	Epilepsy	Glaucoma	Cancer Treatment
Hepatitis A	Angina	Depression	Psychiatric Treatment
Hepatitis B	Stroke	Migraine	High Blood Pressure
Hepatitis C	Sleep Apnoea	Palpitations	Hives or Skin Rash

11. Are you taking or have you ever taken any medication for Osteoporosis (Bisphosphonate Drugs)?

☐ Yes ☐ No

If yes, please explain

12. Do you smoke? (cigs, vaping, marijuana, etc)

☐ Yes ☐ No *How many per day?*

13. Do you drink alcohol?

☐ Yes ☐ No *How much per week?*

14. Do you have a My Health Record? ☐ Yes ☐ No

15. Is there anything else about your health we should know?

I agree the above information is to the best of my knowledge true and correct

Signature Date