

# Medical history



Dr/ Mr/ Mrs/ Ms/ Miss/ Master

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Mobile Number: \_\_\_\_\_ Name of Dental Health Fund: \_\_\_\_\_

Email Address: \_\_\_\_\_

Person to contact in case of an emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us? (Please circle or comment)

Internet \_\_\_\_\_ Other dentist \_\_\_\_\_ Publication \_\_\_\_\_

Yellow Pages \_\_\_\_\_ Personal referral \_\_\_\_\_ Flyer \_\_\_\_\_

Date of your last dental treatment? \_\_\_\_\_ Last dental cleaning? \_\_\_\_\_ Last full mouth x-rays? \_\_\_\_\_

Do you feel nervous about your dental treatment? Yes / No (Please circle)

Are you currently undergoing any medical treatment? Yes / No (Please circle) If so with whom?  
Physicians Name \_\_\_\_\_ Phone \_\_\_\_\_

Are you currently taking any medication? Yes / No (Please circle)  
If yes, name of medication and dosage: \_\_\_\_\_

Do you have any allergies? eg. Penicillin, Aspirin, Codeine, Erythromycin, Other Yes / No (Please circle)

If yes, please specify: \_\_\_\_\_

Please indicate below if you have had or have presently any of the following: (Please circle)

Arthritis/ Rheumatism Yes / No

Artificial Heart Valve Yes / No

Artificial Joints (hip, knee) Yes / No

Asthma Yes / No

Chest Pain Yes / No

Congenital Heart Disease Yes / No

Diabetes Yes / No

Diet (special, restricted) Yes / No

Emphysema / Chronic Cough Yes / No

Epilepsy Yes / No

Fainting / Dizzy Spells Yes / No

Haemophilia Yes / No

Heart (Surgery, disease, attack) Yes / No

Heart Murmur Yes / No

Heart Pacemaker Yes / No

Hepatitis ( A / B / C ) Yes / No

High Blood Pressure Yes / No

HIV / AIDS Yes / No

Latex sensitivity Yes / No

Mitral Valve Prolapsed Yes / No

Radiation / Chemotherapy Yes / No

Rheumatic Fever Yes / No

Sinus troubles Yes / No

Stomach Ulcers Yes / No

Stroke Yes / No

Thyroid Problems Yes / No

Tuberculosis Yes / No

Are you pregnant? Yes / No / Maybe (Please circle)

Breastfeeding? Yes / No (Please circle)

Are you a smoker? Yes / No (Please circle) If yes, how many per day? \_\_\_\_\_

Are you interested in the following? (Please circle)

Whitening

Veneers

Tooth Replacement

Teeth Straightening

Amalgam Removal

**I understand that all treatment is to be paid for on the day of treatment and that all information collected will be treated in confidence.**

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_