MEDICAL HISTORY FORM

It is important to know the details about your medical history as these could affect the success of your dental treatment. The information you provide is confidential and will be handled in accordance with the Australian Dental Association privacy policy.

Last name:	
Title: Mr / Mrs / Ms / Miss / Dr / Others:	
First name(s):	
Date of birth: / /	Gender: M / F
Home address:	
Phone (Home):	Phone (Work):
Mobile:	Email:
Do you have any private Health Fund? N / Y , If *Yes*, Which one?	
Occupation:	
How did you find us?	If *Newspaper*, Which one?
Contact of your medical practitioner :	Ph:
Contact in case of emergency:	Ph:

MEDICAL HISTORY	**No**	**Yes**	**DETAILS**
Are you being treated by a doctor at present?	☐	☐	
Are you taking any tablets or medicines (prescribed or over-the-counter) at present?	☐	☐	
Do you normally require antibiotic cover berfore dental treatment?	☐	☐	
Have you had any abnormal reactions to local or general anaesthesia ?	☐	☐	
Do you smoke?	☐	☐	
Are you pregnant? (*Female only*)	☐	☐	
Please list any drugs or medicines you are allergic to:			
Please list any other known allergies (including latex):			

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	No	**Yes**		**No**	**Yes**		**No**	**Yes**
Asthma			Thyroid disease			Transplanted organ or marrow		
Nervous condition			Kidney disease			Cardiac pacemaker		
Steroid therapy			Heart complaint			Stomach or digestive condition		
Stroke			Heart murmur			Hepatitis or other liver diseases		
Epilepsy			Tuberculosis			Contact with HIV/AIDS virus		
Diabetes			Rheumatic fever			Prosthetic implant e.g. Artificial hip		
Excessive bleeding			Heart valve disorde			Anaemia, leukaemia or other blood diseases		
High or low blood pressure			Radiation therapy			Bronchitis, emphysema or other lung diseases		

Any other condition(s):

PLEASE LIST ANY CONCERNS THAT YOU HAVE WITH YOUR TEETH AND ORAL HEALTH:

Your Signature:	Date: