DENTAL MEDICAL HISTORY FORM

Private and Confidential

Please provide adequate details or discuss them with your dentist

FAMILY NAME: _____ GIVEN NAMES: _____

DATE OF BIRTH: _____/_____/_____ SEX: Male / Female

PHONE: _____ MOBILE: _____ WORK: _____

ADDRESS: _____ POSTCODE: _____

INDIGENOUS STATUS: Please circle ABORIGINAL TORRES STRAIT ISLANDER BOTH NEITHER

NAME OF YOUR DOCTOR: _____ CONTACT NUMBER: _____

MEDICARE NUMBER: ____ ____ ____ ____ ____ ___ ____ ____ ____ _____

POSITION ON MEDICARE CARD: _____ EXPIRY DATE: _____ / _____

HEALTH CARE or PENSION CARD NUMBER: _____ EXPIRY DATE: ____ / ____ / _____

Allergies (Latex; Penicillin; any other drug; etc): _____

_____

Current Medications (prescription, over the counter, herbal): _____

_____

Do you smoke? Yes / No If Yes, how many per day? _____

Do you take alcohol? Yes / No

If female, are you pregnant? Yes / No If Yes, due date? _____

Is there anything you would like to discuss with the dentist in private? Yes / No

Past / Current medical conditions:

Are you receiving any medical treatment at present? Yes / No Details: _____

_____

Have you had any serious or long standing illness? Yes / No Details: _____

_____

Have you ever been hospitalised? Yes / No Details: _____

Please indicate if you have EVER had any of the following:

Any heart complaint/treatment	_____	Tuberculosis	_____
Rheumatic fever or heart valve surgery	_____	Any Nervous System Disorder	_____
High or Low Blood Pressure	_____	Gastric Ulcer	_____
Blood Disorder	_____	Asthma / Bronchitis / Lung conditions	_____
Anti-coagulant Therapy	_____	Radiation Therapy / Chemotherapy	_____
Joint Replacement Surgery	_____	Thyroid Disease	_____
Osteoporosis or Low Bone Density	_____	Hepatitis, Jaundice or Liver Disease	_____
Epilepsy	_____	Treatment for any form of Cancer	_____
Diabetes	_____	Transplanted Organ or Bone Marrow	_____
HIV	_____	Other _____	

I agree that the information provided above is a true and accurate record Signature: _____

Date: _____