

MEDICAL HISTORY FORM

Last Name _____ Title _____ First Name _____

Preferred Name _____ Date of Birth _____

Residential Address _____ Postal Address _____

Home Phone _____ Work Phone _____

Mobile Phone _____ (Please tick preferred phone contact)

Email address _____ Health Fund _____ I.R.N.. _____

Medicare No. _____ Expiry ___/___ I.R.N. _____ DVA Number _____

Employer _____

Pension Card holder Health Care Card holder Seniors' Card holder

Emergency Contact _____ Phone _____ Address _____

Do you require an interpreter service? Are you of Aboriginal and/or Torres Strait Islander origin?

Medical Practitioner _____ Address _____

How did you hear about us? _____

Please list **all** medications including non prescription medications _____

Do you have or have ever had any of the following?	Yes	No		Yes	No
Allergies or reactions to anything	<input type="radio"/>	<input type="radio"/>	Kidney or liver impairment	<input type="radio"/>	<input type="radio"/>
Local anaesthetic problems	<input type="radio"/>	<input type="radio"/>	Have you ever been prescribed Bisphosphonates?	<input type="radio"/>	<input type="radio"/>
Bleeding following procedures or poor healing	<input type="radio"/>	<input type="radio"/>	Psychiatric treatment	<input type="radio"/>	<input type="radio"/>
Heart attack	<input type="radio"/>	<input type="radio"/>	Cancer and/or tumour	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>	Chemo and/or radiation treatment	<input type="radio"/>	<input type="radio"/>
Prosthetic heart valve	<input type="radio"/>	<input type="radio"/>	Stroke and/or cerebrovascular event	<input type="radio"/>	<input type="radio"/>
Heart or cardiovascular system problems	<input type="radio"/>	<input type="radio"/>	Sinus trouble	<input type="radio"/>	<input type="radio"/>
Prosthetic joints	<input type="radio"/>	<input type="radio"/>	Thyroid trouble	<input type="radio"/>	<input type="radio"/>
Rheumatic fever	<input type="radio"/>	<input type="radio"/>	Pace maker	<input type="radio"/>	<input type="radio"/>
Hepatitis A, B or C	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	Anaemia	<input type="radio"/>	<input type="radio"/>
Tuberculosis	<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	High risk category for HIV	<input type="radio"/>	<input type="radio"/>
Epilepsy	<input type="radio"/>	<input type="radio"/>	Are you pregnant? If yes, due date _____	<input type="radio"/>	<input type="radio"/>
If you answered yes to any of the above, please give details			Other	<input type="radio"/>	<input type="radio"/>

DENTAL HISTORY

Why did you come to the dentist today? _____

Have you ever experienced pain in your jaw or joint (TMJ)? Yes No

Describe your dental health _____

When was your last dental visit? _____

Have you ever had a problem with dental work? Yes No

Are you currently in pain? Yes No

Are you happy with the appearance of your smile? _____

Do you have Nitrous Oxide (Happy Gas) during dental treatment Yes No

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorise the dental staff to perform any necessary dental services with my informed consent that I may need during diagnoses and treatment.

Signature _____ **Date** _____

Thank you for taking the time to fill out this form. Our office is committed to meeting or exceeding the standards of infection control advocated by the Australian Dental Association.

Please email this completed form to info@maitlanddentist.com.au or bring it with you to your appointment.