MEDICAL HISTORY FORM

Title _____ Surname_____ First name_____

Preferred Name _____Date of birth _____

Address _____ Suburb_____Post Code_____

Home phone _____ Mobile _____ Email _____

Occupation _____ Private health fund _____

Next of Kin _____ Contact _____

Name of your physician _____

Address_____ Phone _____

Have you had any of the following?

Heart problems	Yes/No	Blood pressure	High/Low
Artificial joints	Yes/No	Rheumatic Fever	Yes/No
Circulatory problems	Yes/No	Radiation treatment	Yes/No
Excessive bleeding	Yes/No	Excessive bruising	Yes/No
Ulcers (stomach)	Yes/No	Sinus trouble	Yes/No
Tumour history	Yes/No	Anaemia	Yes/No
Blood disorders	Yes/No	Diabetes	Yes/No
Asthma	Yes/No	Hepatitis A B C D E	Yes/No
Epilepsy	Yes/No	Liver/kidney problems	Yes/No
Arthritis	Yes/No	Osteoporosis	Yes/No
Are you pregnant	Yes/No	Do you smoke	Yes/No

Have you ever taken any bisphosphonates (Medication for Osteoporosis) Yes/No

Allergies (penicillin/anaesthetics/medications/latex) _____

Are you currently taking any medications Yes/No If 'yes' please list

_____

_____

How did you hear about us? (Please circle) Friend/Family Signage Google Health engine

Other _____

If you have been referred by a friend or family member please provide us with their name so we may thank them_____

DENTAL HISTORY

When was your last dental appointment? _____

Do your gums ever bleed when you brush	Yes/No
Have you ever had gum disease	Yes/No
Do you think you have occasional bad breath	Yes/No
Do you experience sensitivity to hot/cold	Yes/No
Does your jaw click or hurt	Yes/No
Do you grind your teeth	Yes/No
Are you nervous about seeing the dentist	Yes/No

Are you Happy with the appearance of your teeth	Yes/No
Have you ever had botox/dermal fillers	Yes/No

Would you like more information on:

- Tooth whitening
- Invisalign
- Smile makeovers
- White fillings
- Botox/ dermal fillers

DECLARATION: I verify that that the information I have provided is accurate. I understand that all information provided will be treated with complete confidentiality. I will advise my dentist of any changes in the future.

I understand that payment is due at the time of service and cancellations without appropriate notice (24 hours) or missed appointments may incur a fee.

Please sign one line below.

Signature _____ Date _____