MEDICAL HISTORY FORM

You are very welcome to our Dental Practice. Please take a few minutes to complete these details as completely as you can. All questions are relevant to modern Dental practice. We value your privacy and we will comply with our privacy policy which you can view on our Frenchville Dentists website. *www.frenchvilledentists.com.au*

Personal details

Title *(eg Mr/Mrs/Ms): ……* **Family Name: ……..**

First Name(s): ……

Date of Birth: …….

Home Address: ……..
Postcode: ……

Postal Address: ……..
Postcode: ……

Phone - *Home:* …….. *Work*: ……..

***Mobile*: ……**

Email Address: ……..

In case of an emergency, a contact person and their phone number:
……..
Ph: …….. Relationship to this person: ……

How did you find out about us? ……..

If patient is under 18, parents/guardians name and relationship to the child:
……..

Continued over page ⟶

Frenchville Dentists

It is important to know details about your medical history as these could affect the nature of your dental treatment and also to ensure that we can provide treatment safely for you. The information you provide is confidential and will be handled in accordance with our privacy policy. Your Dentist will assess this information and may ask you further questions.

General Medical Information

I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this *(please tick box).* ☐

	Yes	No
Are you taking **any prescription or other** medications at present?		
Have you been hospitalised in the last 12 months?		
Are you being treated by a doctor at present?		
Do you smoke?		
Have you had any abnormal reactions to local or general anaesthesia?		
Do you normally require antibiotic cover before dental treatment?		

FOR FEMALES:

Are you pregnant?		
Are you taking oral-contraceptives?		

Please list current medications: *(including non-prescriptions, blood thinners and supplements)*

……

……

……

Who is your medical practitioner? ……..

Please list any materials or medications you are allergic to:

……

Please list any other known allergies *(including latex, foods and preservatives)*:

……

Detailed Medical Information

DO YOU CURRENTLY SUFFER FROM, OR HAVE HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?
Please tick either yes or no for each condition

	Y	N		Y	N		Y	N
Diabetes			Osteoporosis			Kidney disease		
Asthma			High or low blood pressure			Steroid therapy		
Epilepsy			Radiation therapy			Tuberculosis		
Bone disease			Thyroid disease			Cancer		
Cardiac pace maker			Rheumatic fever			Stroke		
Heart disease or disorder			Prosthetic implant eg. Joint replacement			Nervous or mental condition		
Bronchitis, emphysema or other lung diseases			Blood borne disease, or bleeding disorders			Digestive condition including reflux		
Liver disease, Hepatitis								

Any other condition(s) not mentioned (*please list*):

……

……

Please list any other concerns or problems that you have with your teeth or mouth:

……

……

It is very important that you inform us of any changes in this information at consecutive appointments.

As you would find with most health service providers, <u>you are expected to settle fees at the time of treatment</u>. We are very happy to discuss fees before your treatment.

I have read and understood this questionnaire and answered these questions to the best of my knowledge.

Your / Guardian's signature: ……
Date: ……