Your Medical History Form

Dental Practice ACCREDITED

Mr / Master / Mrs / Ms / Miss / Dr / no title / other (*please circle*)

FIRST NAME _____ SURNAME _____

Date of birth _____

ADDRESS _____

SUBURB _____ POSTCODE _____

EMAIL _____

PHONE (Mobile) _____ (Work) _____ (Other) _____

Occupation & Employer _____

GP or other practitioner name & contact number _____

Person responsible for payment _____ Private Health Fund & Membership Number _____

Whom may we thank for referring you to us? _____

PRIVATE AND CONFIDENTIAL

	Y	N
I have private and confidential medical information which I do not wish to write down	☐	☐
I would prefer to speak to the dentist in private about this	☐	☐
Are you at present receiving **medical treatment**?	☐	☐

Please list **any medicines or tablets** you are taking (including oral contraceptives) _____

	Y	N
Rheumatic Fever	☐	☐
Cardiac Pacemaker	☐	☐
Diabetes	☐	☐
HIV/AIDS	☐	☐
Epilepsy	☐	☐
Thyroid Disease	☐	☐
Tuberculosis	☐	☐
Asthma	☐	☐
Osteoporosis	☐	☐
Gastric Ulcer	☐	☐
Daytime tiredness/sleepiness	☐	☐
Diagnosed Sleep Apnea	☐	☐
Do you use CPAP or an oral anti-snoring device?	☐	☐
Smoking	☐	☐
Nervous system disorder	☐	☐
Hip, joint or heart prosthesis - (L) or (R)	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Have you ever had radiation therapy for cancer/other?	☐	☐
Do you take Alendronate Sodium (e.g. Fosamax)?	☐	☐
Do you bruise or bleed easily?	☐	☐

Do you have an allergy to penicillin, anesthetics or other drugs? *Please give details:*

_____

Do you have an allergy to any chemicals or substances (e.g. antiseptics, latex, chlorine, etc)? *Please give details:*

_____

Do you have any blood disorders? *Please give details:*

_____

Do you have any heart or blood pressure conditions? *Please give details:*

_____

Do you have any other medical conditions not listed here? *Please give details:*

_____

_____

Are you pregnant? YES or NO If YES, when are you due? _____

In signing this form, I acknowledge that this represents an accurate medical history. I will also supply my dentist with any relevant changes to this history as required. I agree to pay Central Leederville Dental all charges and any expenses or disbursements incurred by recovering outstanding monies, including debt collection fees. I acknowledge I need to give the practice sufficient notice (48-hours) to cancel my appointments, or I may be charged a cancellation fee. All medical information will be treated with complete professional confidentiality. I have read and agree to the Privacy Act presented to me.

Signed _____ Date _____

Signed _____ Date _____

Signed _____ Date _____

Signed _____ Date _____