Deakin Dental

Medical History form

Date ___ / ___ / ___

About You

Title (Mr, Mrs etc.)

First name

Surname

Preferred name

Gender

Marital Status

Birthdate ___ / ___ / ___

Home address

Phone Number (H)

(M)

(W)

Email Address

Preferred contact ☐ Phone ☐ Email ☐ Text

Occupation

Employer

Dental Health fund ☐ Yes ☐ No

Details:

Previous Dentist

Last visit date

Your Health

Do you have a GP? ☐ Yes ☐ No

GP Name

Contact number

Date of last visit

Current health ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

For women: Are you pregnant? ☐ Yes ☐ No (Weeks)

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or serious medical problems?

- ☐ Abnormal bleeding
- ☐ Alcohol/Drug Abuse
- ☐ Anaemia
- ☐ Arthritis
- ☐ Artificial Bones/Joints/Valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Haemophilia
- ☐ Hepatitis
- ☐ Herpes/Fever Blisters
- ☐ High Blood Pressure
- ☐ HIV+/AIDS
- ☐ Hospitalised for Any Reason
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic/Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease/Traits
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease

or other (please list)

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anaesthetics
- ☐ Erythromycin
- ☐ Jewellery
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Tetracycline

or other (please list)