GOODNA DENTAL

3/23 Queen Street
Goodna Qld4300
Phone: 07 3381 9992
Fax: 07 3818 6662

CONFIDENTIAL MEDICAL/DENTAL HISTORY FORM

It is important to know details about your medical history as these could affect the success of oral health care (dental treatment).
The information you provide is confidential.

FIRST NAME(S):	TITLE (*EG MR/MRS/MS*):
LAST NAME:	DATE OF BIRTH: / /
HOME ADDRESS:	PH (HOME):
	MOBILE:
EMAIL:	WORK:

HEALTH FUND: ☐ NO ☐ YES, PLEASE SPECIFY:

MEDICARE # REF# EXPIRY:

CONTACT IN CASE OF EMERGENCY:	PH:
MEDICAL PRACTITIONER:	PH:
ADDRESS:	FAX:

	NO	YES		NO	YES
DO YOU NORMALLY REQUIRE ANTIBIOTIC COVER BEFORE DENTAL TREATMENT?			DO YOU SMOKE?		
HAVE YOU ANY ABNORMAL REACTIONS TO LOCAL OR GENERAL ANAESTHESIA?			ARE YOU PREGNANT OR BREAST FEEDING? *(FEMALES ONLY)*		

PLEASE LIST ANY **TABLETS** OR **MEDICINES** (PRESCRIBED OR OVER THE COUNTER) YOU ARE TAKING AT PRESENT?

PLEASE LIST ANY DRUGS OR MEDICINES YOU ARE **ALLERGIC** TO:

PLEASE LIST ANY OTHER KNOWN **ALLERGIES** (*INCLUDING LATEX*):

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS?
(Please tick appropriate box(es)

	NO	YES		NO	YES		NO	YES
Steroid Therapy			Kidney Disease			Prosthetic implant eg artificial hip		
Rheumatic Fever			Excessive Bleeding			Cardiac pacemaker		
Epilepsy			Heart complaint			Stomach or digestive condition		
Asthma			Nervous condition			Hepatitis or other liver disease		
Diabetes			Tuberculosis			Contact with HIV/AIDS virus		
Heart valve disorder			Thyroid disease			Stroke		
Anaemia, leukaemia or other blood diseases			High or low blood pressure			Bronchitis, emphysema or other lung diseases		
Radiation therapy			Heart murmur			Transplanted organ or marrow		

Any other condition(s) *(please list):*

PLEASE LIST ANY CONCERNS THAT YOU HAVE WITH YOUR TEETH OR MOUTH:

REFERRED BY: ☐ Street Sign ☐ Another patient/friend (Name)

☐ Brochure ☐ Internet ☐ Yellow Pages ☐ Other (Please List)

SIGNATURE: Patient/Parent/Guardian: ________________________________

NAME OF PERSON SIGNING (if not the patient): ____________________________

DATE:_______/________/_________

Office use only:

☐ Medicare/ID sighted
☐ Patient History filled
☐ Patient sign & date
☐ Initial: