

			MEDICAL HISTORY FORM								
It is important to know the details about your medical history as these could affect the success of your dental treatment. The information you provide is confidential and will be handled in accordance with the Australian Dental Association privacy policy.											
Last name:											
Title: Mr / Mrs / Ms / Miss / Dr / Others:											
First name(s):											
Date of birth: / /					Gender: M / F						
Home address:											
Phone (Home):					Phone (Work):						
Mobile:					Email:						
Do you have any Private Health Fund? N / Y , If Yes, Which one?											
Are interested in whitening your teeth?											
How did you find us?											
Contact of your medical practitioner :							Ph:				
Contact in case of emergency:							Ph:				
MEDICAL HISTORY											
					No	Yes	DETAILS				
Are you being treated by a doctor at present?					<input type="checkbox"/>	<input type="checkbox"/>					
Are you taking any tablets or medicines (prescribed or over-the-counter) at present?					<input type="checkbox"/>	<input type="checkbox"/>					
Do you normally require antibiotic cover before dental treatment?					<input type="checkbox"/>	<input type="checkbox"/>					
Have you had any abnormal reactions to local or general anaesthesia ?					<input type="checkbox"/>	<input type="checkbox"/>					
Do you smoke?					<input type="checkbox"/>	<input type="checkbox"/>					
Are you pregnant? (<i>Female only</i>)					<input type="checkbox"/>	<input type="checkbox"/>					
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?											
No			Yes			No			Yes		
Asthma			Thyroid disease			Transplanted organ or marrow					
Nervous condition			Kidney disease			Cardiac pacemaker					
Steroid therapy			Heart complaint			Stomach or digestive condition					
Stroke			Heart murmur			Hepatitis or other liver diseases					
Epilepsy			Tuberculosis			Contact with HIV/AIDS virus					
Diabetes			Rheumatic fever			Prosthetic implant e.g. Artificial hip					
Excessive bleeding			Heart valve disorder			Anaemia, leukaemia or other blood diseases					
High or low blood pressure			Radiation therapy			Bronchitis, emphysema or other lung diseases					
Any other condition(s):											
PLEASE LIST ANY CONCERNS THAT YOU HAVE WITH YOUR TEETH AND ORAL HEALTH:											
Your Signature:							Date:				