



NEW PATIENT MEDICAL / DENTAL HISTORY FORM

Please note that all information on this form will remain strictly confidential. Please fill out clearly.

Contact Information

Mr / Mrs / Miss / Ms / Other: _____

First Name: _____

Date of Birth: _____

Address: _____

State: _____ Postcode: _____

Last Name: _____

Preferred Name: _____

Phone (Home): _____

Phone (Mobile): _____

Email Address: _____

Are you a member of a private health fund? If yes please state _____

Other Contacts

Emergency Contact
Name: _____

Emergency Contact
Phone: _____

Complete this only if the patient is under 18 years of age

Guardian Name: _____

Guardian Phone: _____

Guardian Address: _____

Medical History

Name of Your GP: _____

Your Doctor's Phone: _____

Your Doctor's Address: _____

Have you ever had any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumours |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Psychological Disorders |
| <input type="checkbox"/> Bone disorders e.g. osteoporosis | | |

Are you pregnant, and if so how many months? _____



Have you had any serious illnesses in the last 2 years?

If yes, please provide more information. _____

Are you currently taking any medications or tablets regularly?

If yes, please provide the name of the medication. _____

Do you take any tablets or injections that affect your bones? _____

Do you have any allergies to Penicillin or other drugs?

If yes, please provide the name of the medications you are allergic to. _____

Do you suffer from sleep apnoea? _____

Is your blood pressure normal, high or low? _____

Do you smoke? If so how many per day? _____

DENTAL HISTORY

Are you concerned about or experiencing any of the following dental problems? (please tick as many as it applies)

- | | | |
|--|--|---|
| <input type="checkbox"/> Sensitivity to hot or cold | <input type="checkbox"/> Staining of your teeth | <input type="checkbox"/> Food trapping between your teeth |
| <input type="checkbox"/> Clicking/pain in the jaw joints | <input type="checkbox"/> Discoloured fillings | <input type="checkbox"/> Roughness of existing fillings |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Sensitivity when eating |
| <input type="checkbox"/> Head/neck ache | <input type="checkbox"/> Grinding or clenching of your teeth | |

Are you concerned with: (please tick as many as it applies)

- | | | |
|---|---|--|
| <input type="checkbox"/> Ability to eat | <input type="checkbox"/> your smile | <input type="checkbox"/> Silver fillings |
| <input type="checkbox"/> Gaps between your teeth | <input type="checkbox"/> Discolouration of your teeth | <input type="checkbox"/> Previous dental treatment |
| <input type="checkbox"/> Existing crowns, bridges or dentures | | <input type="checkbox"/> Crooked teeth |
| <input type="checkbox"/> Tooth cleaning techniques (e.g. brushing & flossing) | | <input type="checkbox"/> Missing teeth |

What is the main purpose of your visit today? _____

How long since your last dental visit? _____

Does dental treatment make you nervous? No Slightly Moderately Extremely

Have you ever had or require the following for dental treatment?

- Gas (Nitrous oxide-laughing gas) Intravenous sedation General anaesthesia

Do you grant permission for your case to be used for continuing dental education/lecturing? Yes No

How did you hear about us?

- Google Facebook Yellow pages Referred by doctor / dentist Friend or Family Website
 Other _____

Signed: _____

Full Name: _____

Date: _____