|  |
| --- |
| **Practice Database Patient History Sheet**  Title:................. First Name: .................................................................. Surname:........................................................  Home Address:....................................................................................................................................................................  Suburb:................................................................................................... Postcode: ..................................  Ph: ............................................... Wk Ph: ............................................. Mobile:..............................................................  E-mail: ..........................................................................................................DOB: ……………………………………………  Name of Person Responsible for fees:............................................................................ Relation: ...................................  Healthfund:……………………………………………. (If you ever change Health Funds, please let one of our friendly staff know)  Emergency Contact: ....................................................................................... Ph:................................................  Medical Doctor: .............................................................................................. Ph: ...............................................  How did you find us? Website Google Facebook Walkin Yellow Pgs Other:...............................................  If a family or friend referred, please name:......................................................................................................................... |

|  |  |  |  |
| --- | --- | --- | --- |
| **Confidential Medical History** | | | |
| *Please confirm details as relevant and leave other fields blank* | | | |
| **Lifestyle** | | | |
| Smokes (per day) |  | High sugar |  |
| Chew tobacco (per day) |  | Lots of fizzy/acidic drinks |  |
| Alcohol (units per week) |  | Recreational drugs |  |
| Pregnancy or possibly pregnant |  | Please add anything dentist should know | |
| If you are pregnant … please confirm how many weeks. | | |  |
| Details | | | |
| **Heart** | | | |
| Rheumatic Fever |  | Heart Murmur |  |
| High or Low Blood Pressure |  | Angina |  |
| Heart Surgery |  | Thrombosis |  |
| Pacemaker fitted |  | Other Heart Conditions |  |
| Details | | | |
| **Blood** | | | |
| Hepatitis A,B,C or D |  | Anaemia |  |
| H.I.V/ AIDS |  | Sickle Cell |  |
| Abnormal Blood Test |  | Haemophilia |  |
| Blood refused by transfusion svce |  | Other Blood Conditions |  |
| Details | | | |
| **Allergies** | | | |
| Penicillin |  | Latex Allergy |  |
| Hay Fever |  | Medicines |  |
| Anti-Tetanus Serum |  | Plants |  |
| Eczema |  | Foods |  |
| General Anaesthetic |  | Aspirin |  |
| Local Anaesthetic |  | Other Allergy Conditions |  |
| Details | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Warnings** | | | |
| Hearing/ Sight Impairment |  | Do Not Recline |  |
| Antibiotic Cover required |  | Steroids within 2 years |  |
| Bruising or persistent bleeding |  | Warning Card |  |
| Currently under treatment |  | Treatment requiring hospital |  |
| Details | | | |
| **Chest** | | | |
| Bronchitis |  | Emphysema |  |
| Cystic Fibrosis |  | Pneumonia |  |
| Pleurisy |  | Chest Surgery |  |
| Asthmatic |  | Other Chest Conditions |  |
| Details | | | |
| **Other Conditions** | | | |
| Liver Disease |  | Kidney Disease |  |
| Diabetes |  | Epilepsy |  |
| Acid Reflux or Eating Disorder |  | Hiatus Hernia |  |
| Bone or Joint Disease |  | Artificial Joint |  |
| Fainting Attack or Blackouts |  | Giddiness |  |
| Past serious or infectious disease |  | Cancer/ Radiotherapy |  |
| Depressive Illness |  | Stroke |  |
| Nervous Problems |  | Tuberculosis |  |
| Severe Headaches |  | Cold Sores |  |
| **Medications** | | | |
|  | | | |

I have completed this Questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue medical risk. I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give my permission for the practice to use the above contact details to send me appointment and preventative care recall reminders.

Signed by: Guardian/Patient: .............................................................................. Date: ....................................

Name: ..............................................................................

**ON FUTURE VISITS ANY CHANGES TO THE ABOVE SHOULD BE ADVISED.   
AT ANY STAGE IF YOU HAVE CHANGED HEALTHFUNDS OR ARE PLANNING TO CLAIM THROUGH ONE OF THE FOLLOWING SCHEMES VETERAN AFFAIRS, MEDICARE CHILD DENTAL SCHEME, DEPARTMENT OF HUMAN SERVICES – EMERGENCY DENTAL SCHEME OR GENERAL DENTAL SCHEME, PLEASE LET ONE OF OUR FRIENDLY STAFF MEMBERS KNOW.**

**SMILE ☺**