All Smiles
FAMILY DENTISTRY

MEDICAL HISTORY FORM

Title: Mr, Master, Mrs, Miss, Ms, Dr, Prof.

Surname: _____ First Name: _____

DOB: _____/_____/_____ Email: _____

Address:_____Suburb:_____

Ph: (H) _____ (W) _____ (M) _____

Dental Insurance: HCF/AHM/BUPA/NIB Other: _____ Occupation: _____

Are you being treated by a Doctor at present? Yes / No

Are you taking any medication? Yes / No

Please list all Medication / Tablets_____

Have you been a hospital patient in the last five years? Yes / No

Has your Medical Practitioner recommended antibiotic cover before dental treatment? Yes / No

Who is your General Practitioner? _____ Phone: _____

Please list any drugs/materials you are allergic to _____

PAST MEDICAL HISTORY: Please tick all that apply

□ Rheumatic Fever	□ Heart Complaint	□ Thyroid condition
□ Epilepsy	□ High Blood pressure	□ Nervous condition
□ Asthma	□ Smoker	□ Stroke
□ Diabetes	□ Anaemia	□ Prosthetic Implant
□ HIV/AIDS virus	□ Tuberculosis	□ Heart Valve Disorder
□ Kidney disease	□ Hepatitis A B C	□ Cardiac Pacemaker
□ Excessive bleeding	□ Seizures	□ Latex Allergy

Other: _____

I have confidential Information that I would prefer to speak to the Dentist about Yes / No

Ladies are you or might you be pregnant Yes / No Due Date? _____

Please list any previous problems you have experienced with dental treatment?

_____

How did you find our Dental Practice?

□ Yellow Pages □ Google □ Downstairs □ Radio □ Friend/Relative □ Other _____

Emergency Contact:_____Relationship:_____Ph:_____

Signature: _____Date: _____

Parent/Guardian Name: _____Date: _____

Please advise us promptly of any changes to your medical history as they may affect your dental health

Update:

Signature: _____Date: _____

Please turn over

DENTAL HISTORY FORM

Name:_____ DOB:_____

Last dental exam? _____ Date of most recent dental X-rays:_____

I routinely see my dentist every: (please circle) 3 month 6 month 12 month only when something is wrong

What are your expectations for today's appointment? _____

Please circle YES or NO to the following:

Personal Dental History_____

Are you fearful/nervous about dental treatment? NO YES_____

Have you ever had any complications from past dental treatment NO YES_____

Have you ever had trouble getting numb or had any reactions to the local anesthetic NO YES_____

GUM AND BONE_____

Do your gums bleed or are they painful when you brush or floss? NO YES_____

Have you ever been treated for gum disease or being told you have lost bone around your teeth? NO YES

Do you know if there is anyone with a periodontal disease in your family? NO YES_____

Have you ever experienced gum recession? NO YES_____

TOOTH STRUCTURE_____

Have you had any cavities in the last 3 years? NO YES

Do you feel or notice any holes, sensitivity, grooves or notches in your teeth? NO YES_____

Do you frequently get any food caught between any teeth? NO YES_____

BITE AND JAW JOINT_____

Do you have problems with your jaw joint (pain, sounds, limited opening, locking) NO YES_____

Have your teeth changed in the last 5 years: become shorter, thinner, worn? NO YES_____

Are your teeth becoming crooked, overlapping or developing spaces? NO YES_____

Do you clench your teeth in the daytime making them sore? NO YES

Do you have any problems after waking up for eg: wake with a headache, soreness of teeth? NO YES_____

SMILE CHARACTERISTICS_____

Are your happy with your smile? YES NO What would you like to change_____

Have your ever whitened your teeth? YES NO Would you like to? YES NO

Have you been happy with your previous dental work? YES NO_____

Is there anything specific you would like to discuss with the dentist? NO YES_____

Patient/Guardians Signature_____Date_____