MEDICAL/DENTAL HISTORY FORM

ADA QUEENSLAND

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 and will be handled in accordance with our privacy policy which is shown on the reverse of this form.

Last name:	Title *(eg Mr/Mrs/Ms):*
First name(s):	Date of birth:
Home address:	Postcode
Phone (Home):	(Work):
Contact in case of emergency:	Phone:
I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this. *(please tick box)*	

	No	Yes	Details
Are you being treated by a doctor at present?			
Are you taking any tablets or medicines (prescribed or over-the-counter) at present?			
Do you normally require antibiotic cover before dental treatment?			
Have you had any abnormal reactions to local or general anaesthesia?			
Do you smoke?			
Are you pregnant? *(Females only)*			

Who is your medical practitioner? Phone

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 e.g. artificial hip		
Rheumatic fever			Excessive bleeding			Cardiac pacemaker		
Epilepsy			Heart complaint			Stomach or digestive condition		
Asthma			Nervous condition			Hepatitis or other liver diseases		
Diabetes			Tuberculosis			Contact with HIV/AIDS virus		
Heart valve disorder			Thyroid disease			Bronchitis, emphysema or other lung diseases		
Stroke			Heart murmur			Anaemia, leukaemia or other blood diseases		
Radiation therapy			High or low blood pressure			Transplanted organ or marrow		

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

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

	Office use only
Your signature:	Date: