# PATIENT PERSONAL DETAIL & MEDICAL HISTORY FORM

*Welcome to our Practice! Please answer these questions as completely as possible*

LIFETIME DENTAL CARE

Name (Mr/Mrs/Miss/Dr/Other): _____

(First Name/s) (Family Name)

Address: _____

_____ Postcode: _____

Date of Birth: _____ Email: _____

Phone (Home): _____ Phone (Mob): _____ Phone (Work): _____

Contact Preference (Circle): Home / Mob / Work Occupation: _____

Private Health Fund (If applicable): _____

Person responsible for payment of accounts: _____

Who can we thank for recommending you to our practice? _____ Google / Other

EMERGENCY CONTACT DETAILS:

Name: _____ Phone: _____ Relationship: _____

***The state of your health may have a very significant effect on your dental care.***

*Please answer these questions fully or discuss them with your dentist*

| | Y | N |
|---|---|---|
| I have private and confidential medical matters which I wish to discuss with the dentist | ☐ | ☐ |
| Are you receiving any medical treatment at present? | ☐ | ☐ |
| Name of your medical practitioner/specialist _____ | | |
| Have you ever been in hospital? If yes, nature and dates of hospitalisation | ☐ | ☐ |

_____

_____

Some medicines may interfere with your dental treatment or react with medicaments used by your dentist. It is important that your dentist knows precisely what medications (if any) that you are taking.

**Please list any medications you are currently taking, or have been taking recently *including*** injections, herbal remedies, vitamins, supplements, cold/flu treatments, sleeping pills, pain relievers, implants, so we can take appropriate precautions and avoid drug interactions.

| Drug Name | Dosage | Duration of Treatment | Purpose/Condition |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please list any known ALLERGIES or ADVERSE REACTIONS to drugs (especially antibiotics eg. Penicillin);** medicines, antiseptics, local anaesthetics, latex, preservatives that we should know about.

| Drug Name | Nature of Reaction | How Long Ago |
|---|---|---|
| | | |
| | | |
| | | |

**If you are in any doubt about your medication, please bring a Pharmacy Medication Summary or the bottle or packet(s) to the practice to show the dentist**

# PATIENT PERSONAL DETAIL & MEDICAL HISTORY FORM

LIFETIME DENTAL CARE

**Please indicate YES or NO if you have ever had any of the following:**

| | Y | N | | Y | N |
|---|---|---|---|---|---|
| Rheumatic fever | ☐ | ☐ | Jaw, neck or shoulder injury/pain | ☐ | ☐ |
| Heart condition/cardiac surgery/pacemaker | ☐ | ☐ | Epilepsy/seizures | ☐ | ☐ |
| Heart valve replacement | ☐ | ☐ | Thyroid disease (including goitre) | ☐ | ☐ |
| High/Low blood pressure | ☐ | ☐ | Tuberculosis (TB) | ☐ | ☐ |
| Blood disorders | ☐ | ☐ | Asthma/Bronchitis/lung conditions | ☐ | ☐ |
| Excessive bruising or bleeding | ☐ | ☐ | Nervous system disorder | ☐ | ☐ |
| Hepatitis, jaundice or liver disease | ☐ | ☐ | Anxiety/Depression | ☐ | ☐ |
| Kidney/renal disease | ☐ | ☐ | Gastroesophageal reflux disease (GORD) | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Cancer or malignancy of any kind | ☐ | ☐ |
| Osteoporosis or low bone density | ☐ | ☐ | Chemotherapy/Radiation therapy | ☐ | ☐ |
| Rheumatoid arthritis/Lupus (SLE)/polymyalgia | ☐ | ☐ | Transplanted organ/bone marrow/stem cells | ☐ | ☐ |
| Joint replacement surgery | ☐ | ☐ | Snoring/Sleep Apnoea | ☐ | ☐ |

Have you ever smoked? Y ☐ N ☐ Approx. date if quit _____ Do your currently smoke or vape? Y ☐ N ☐

If yes, for how long? _____ How much do you smoke _____ per day

Have you ever used illicit substances and/or recreational drugs? Y ☐ N ☐ If yes, when? (Circle) Recent /Over 1yr ago

Do you consume alcohol? Y ☐ N ☐

Do you suffer from any illness not listed above or carry any infectious disease? Y ☐ N ☐

If yes, please provide details _____

_____

***Females*** Are you pregnant or is there a chance you could be pregnant? Y ☐ N ☐ If yes, due date _____

Are you currently breastfeeding? Y ☐ N ☐

## DECLARATION

In signing this form, I acknowledge that this represents an accurate medical history.
I will advise my dentist of any changes to my medical history in the future.
I understand that all medical details will be treated with complete professional confidentiality.
I have read the privacy document provided by this practice.

Patient Signature _____ Date _____

Dentist Signature_____ Date_____

## PRACTICE USE ONLY: Review of Information

Patient Signature _____ Date_____

Dentist Comment _____

_____ Date_____



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