Medical / Dental History Form

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.

Last name:

Title (Mr/Mrs/Ms):

First name(s):

Date of birth:

Home address:

Gender: Male / Female

Phone (Home):

Phone (Work):

Postal address (if different):

Email address:

Contact person in case of emergency:

Phone:

How would you like to be contacted?

☐ Email ☐ SMS ☐ Phone

How did you hear about us?

☐ **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 the box)**

	NO	YES
Are you being treated by a doctor at present? (Please give details)	☐	☐
Are you taking any tablets or medicines (prescribed or over-the-counter) at present? (Please give details)	☐	☐
Do you normally require antibiotic cover before dental treatment? (Please give details)	☐	☐
Have you had any abnormal reactions to local or general anaesthesia? (Please give details)	☐	☐
Do you smoke?	☐	☐
Are you pregnant? (females only)	☐	☐

Who is your medical practitioner? (Name / address)

Please list any drugs or medicines you are allergic to:

Please list any other known allergies (including latex):

DO YOU HAVE, OR HAVE EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS?

(Please tick box(es))

- ☐ Steriod therapy
- ☐ Rheumatic fever
- ☐ Epilepsy
- ☐ Asthma
- ☐ Diabetes
- ☐ Heart valve disorder, eg heartmurmer
- ☐ Stroke
- ☐ Radiation therapy
- ☐ Cardiac pacemaker
- ☐ Stomach or digestive condition
- ☐ Prosthetic or other implant, eg artificial hip, shunt
- ☐ Kidney disease
- ☐ Excessive bleeding
- ☐ Heart complaint
- ☐ Nervous condition
- ☐ Tuberculosis
- ☐ Bronchitis, emphysema or other lung diseases
- ☐ High or low blood pressure
- ☐ Hepatitis or other liver diseases
- ☐ Contact with HIV/AIDS virus
- ☐ Thyroid disease
- ☐ Anaemia, leukaemia or other blood diseases

Any other condition(s) (please list below)

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

In which country were you born? Please tick ONE box, and enter the name of the country if overseas.

☐ Australia ☐ Another country Name of Country

What language is spoken at home?

I consent to health professionals who have treated me exchanging such information about me as may be required to assist in providing oral health care to me. I also consent to information that has been collected by Mobile Dentist, when providing oral health care to me, being used by Mobile Dentist to check and assess the oral health services I have received and how those services have been used, so long as my is not used in any reports or published statistics.

Signed:

Date:

Please email the completed form to: **smile@oncalldentist.com.au**