

Medical/Dental History Review

Dr Mr Mrs Ms Miss Mst

Last Name _____ Given Name(s) _____

Date of Birth _____ Home Ph. _____

Work Ph. _____ Mobile _____

Home Address _____

Suburb _____ Post Code _____

Postal Address _____

Suburb _____ Post Code _____

Email _____ Occupation _____

Emergency Contact _____ Phone _____

Do you normally require antibiotic cover before dental treatment? yes no

Please list any drugs or medicine you are allergic to: _____

Please list any other allergies (including latex and foods): _____

Are you taking any prescription or other medications? yes no

if yes, please specify: _____

Are you taking, or have you ever taken bisphosphonates? yes no

Do you smoke? yes no

Females – Are you pregnant? yes no

Who is your medical practitioner? _____

Do you have now, or have you ever had, any of the following medical conditions? (please tick yes/no)

Steroid therapy	yes <input type="checkbox"/> no <input type="checkbox"/>	High blood pressure	yes <input type="checkbox"/> no <input type="checkbox"/>	Prosthetic implant	yes <input type="checkbox"/> no <input type="checkbox"/>
Rheumatic fever	yes <input type="checkbox"/> no <input type="checkbox"/>	Low blood pressure	yes <input type="checkbox"/> no <input type="checkbox"/>	Stomach condition	yes <input type="checkbox"/> no <input type="checkbox"/>
Epilepsy	yes <input type="checkbox"/> no <input type="checkbox"/>	Stroke	yes <input type="checkbox"/> no <input type="checkbox"/>	Hepatitis A/B/C	yes <input type="checkbox"/> no <input type="checkbox"/>
Asthma	yes <input type="checkbox"/> no <input type="checkbox"/>	Cancer	yes <input type="checkbox"/> no <input type="checkbox"/>	Other liver disease	yes <input type="checkbox"/> no <input type="checkbox"/>
Diabetes	yes <input type="checkbox"/> no <input type="checkbox"/>	Tuberculosis	yes <input type="checkbox"/> no <input type="checkbox"/>	HIV/AIDS	yes <input type="checkbox"/> no <input type="checkbox"/>
Heart complaint	yes <input type="checkbox"/> no <input type="checkbox"/>	Thyroid disease	yes <input type="checkbox"/> no <input type="checkbox"/>	Anaemia	yes <input type="checkbox"/> no <input type="checkbox"/>
Cardiac pacemaker	yes <input type="checkbox"/> no <input type="checkbox"/>	Excessive bleeding	yes <input type="checkbox"/> no <input type="checkbox"/>	Leukaemia	yes <input type="checkbox"/> no <input type="checkbox"/>
Heart valve disorder	yes <input type="checkbox"/> no <input type="checkbox"/>	Radiation therapy	yes <input type="checkbox"/> no <input type="checkbox"/>	Arthritis	yes <input type="checkbox"/> no <input type="checkbox"/>
Heart murmur	yes <input type="checkbox"/> no <input type="checkbox"/>	Kidney disease	yes <input type="checkbox"/> no <input type="checkbox"/>	Other?	yes <input type="checkbox"/> no <input type="checkbox"/>

Any other condition(s) not mentioned: _____

What is the reason for this appointment? _____

When was your last dental visit and what was it for? _____

Do you have any concerns about your teeth, gums or mouth yes no

if yes, please specify: _____

Are you happy with the appearance of your:

Teeth yes no

Gums yes no

Smile yes no

Would you like to discuss how to make your teeth WHITE? yes no

Would you like to discuss enhancing the appearance of your smile? yes no

What don't you like about your smile? _____

Do your gums look and feel healthy? yes no

Do your gums bleed? yes no

Do you clench or grind your teeth? yes no

Does your jaw click or hurt? yes no

How often do you brush your teeth? _____

How often do you floss? _____

Do you have regular hygiene visits (teeth cleaning)? yes no

When was your last hygiene appointment? _____

How did you hear about us? Yellow Pages Yellow Pages Online Weekender

Website Local Directory Sunshine Coast Daily

Family/Friend _____ Other _____

Are you happy to receive practice information via email? yes no

I understand that:

- **3 business days notice is required for an appointment cancellation or a \$65 fee applies**
- **Payment in full is required at the time of treatment**
- **Signing this form will be taken as consent to use before and after photos for patient education and advertising purposes.**

Signature _____

Date _____