Patient Medical History Form

Pymble Dental Practice

**Please answer the below fields as completely as possible to ensure we are able to provide the best dental treatment for you*

Given Names (Mr/Mrs/Miss/Ms/Dr/Other)	Surname	Preferred Name

Date of Birth	Phone Numbers		Occupation
	(Ph)	(Mob)	

Address (Residential)	Suburb	State	Postcode

Address (Mailing) *please list if different to residential address*	Email

Emergency Contact *please list name, relationship and contact phone*	Name of Health Fund (if applicable)	Card Reference

At Pymble Dental we remind our patients when they are due for their check-up, please select how you would like to be reminded

☐ SMS to mobile ☐ Newsletter ☐ Call to home phone

Medical History	Y	N	Comments *please provide detail*
Do you have any dental concerns?			
Are you receiving any current ongoing medical treatment at present?			
Have you been a patient in hospital in the past two years?			
Do you have a heart condition, pacemaker or had cardiac surgery?			
Have you ever undergone radiation treatment or chemotherapy?			
Does your doctor recommend Antibiotic cover before dental treatment?			
Have you ever taken any Bis-Phosphonates? (Drugs for Osteoporosis)			
Are you taking blood thinners e.g. Warfarin, Xarelto, Eliquis or Pradaxa?			
Have you ever experienced excessive bleeding or bruising?			
Do you have any artificial joints or limbs?			
Do you or have you ever smoked? If yes, list when and amount per day			
WOMEN: Are you pregnant?			

Please tick if you have ever had any of the following

Diabetes T1 or T2	Osteoporosis	Hepatitis A B C	Epilepsy/Seizures	Tuberculosis	Anxiety/Depression
Heart Condition	Heart Surgery	Blood Disorder(s)	Thyroid Disease	Cancer	High/Low Blood Pressure
Artificial Joints or limbs	Bone Disorder(s)	Asthma	Kidney/Renal Disease	Glaucoma	HIV

Do you have any illness which is not listed above or do you carry any infectious disease(s)? If yes, please provide details

Medications

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

Drug Name	Dosage	Duration of treatment	Purpose/Condition

Allergies & Adverse reactions

Please list any known allergies or adverse reactions to drugs (antibiotics e.g. penicillin) medicines, antiseptics, local anaesthetics, preservatives

How did you hear about us?

Please circle how you heard about us below

Doctor Referral	Website	Signage	Google	I am an already existing patient	Other

Family/Friends – Please tell us who can we thank?

Privacy: *All information will be treated with privacy and confidentiality as per Commonwealth Government Privacy Act 2002. This includes advising all treating practitioners of relevant medical and dental conditions.*

Signature …….. **Date** ……. /……. / …….

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Dental Practice ACCREDITED