MEDICAL HISTORY FORM

CLEAR CHOICE DENTAL

WELCOME TO OUR SURGERY
Please answer these questions as completely as possible.
It will assist us greatly in our effort to provide the best dental treatment for you.

NAME: Mr/Mrs/Miss/Ms:..... .....
(FIRST NAMES) (SURNAME)

ADDRESS:.....

SUBURB:..... POSTCODE:..... OCCUPATION:.....

DATE OF BIRTH:.....EMAIL:.....

PHONE: (H)..... WORK:..... MOBILE:.....

BEST DAY-TIME CONTACT NUMBER:.....

IN WHICH PRIVATE HEALTH FUND DO YOU BELONG:.....

WHOM MAY WE THANK FOR YOUR REFERRAL:.....

At Clear Choice we respect your privacy and will only use your information and clinical records for research and marketing purposes without releasing your identity.

MEDICAL QUESTIONNAIRE - PRIVATE AND CONFIDENTIAL

To ensure our treatment is compatible with your present state of health, please answer the following:

I have medical concerns in which I want to speak to the dentist in private Y N
Are you at present, receiving medical treatment, if so please give details Y N
.....
Do you suffer from, or carry, any infectious disease.....

Name of your doctor..... Phone.....
Please list any medicines you are taking
(including oral contraceptive, HRT, herbal, naturopathic or 'over the counter' remedies)
.....
.....

Please circle if you have ever had any of the following:

Rheumatic fever Y N

High Blood Pressure Y N

Low Blood Pressure Y N

Blood Disorders Y N

(give details).....

Any heart complaint Y N

Artificial valve.....Y..... N

.....

Do you have a cardiac pacemaker Y N

Hepatitis Y N

(give details).....

Jaundice/liver disease Y N

(give details).....

Allergies to any medicines Y N

(give details).....

Allergy to any foods or chemicals Y N

(give details).....

Epilepsy Y N

Thyroid disease Y N

Tuberculosis Y N

Asthma Y N

HIV/AIDS Y N

Diabetes Y N

Family history of diabetes Y N

Do you smoke Y N

Gastric Ulcer Y N

Joint replacement/s Y N

FEMALES: Are you pregnant Y N

Due Date.....

Are you breast feeding Y N

In signing this form I acknowledge that this represents an accurate medical history and 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.

Signed:..... Date:.....