PrecisionDental

PATIENT MEDICAL HISTORY

These details provide us with information required for your optimal dental treatment and oral health care.
Your Privacy & Confidentiality will be respected at all times. To view our policies please ask for a printout.
It may sometimes be necessary to consult with other health professionals.
Please feel free to discuss any health questions in confidence with your Dentist.

First name(s):	Surname:
Title: Mr / Mrs / Miss / Ms / Dr / Prof / Rev	Occupation:
Date of birth:	Address:
Home phone:	Postcode:
Mobile phone:	Work phone:
Email address:	Preferred contact method: Home / Mobile / Work / Email / SMS only
Private health insurance:	
Name of the emergency contact person:	Their phone number:

I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this. Y / N

	Yes	No	Comments
Do you normally require **antibiotic cover** before dental treatment?			
Have you had any abnormal reactions to local or general anaesthesia?			
Do you smoke?			
Are you pregnant? (Females only)			
Are you being treated by a doctor at present?			
Have you been hospitalised in the last 12 months?			
Are you taking any **prescription or other medication** at present?			

Please list current medications:	
Name of your medical practitioner?	Phone:
Please list any drugs or medicines you are allergic to:	
Please list any other known allergies (including latex, foods and preservatives):	

Do you have now or have you ever had any of the following medical conditions?

	Y	N		Y	N		Y	N
Asthma			Hepatitis B or C			Rheumatic Fever		
Arthritis			HIV / AIDS			Shortness of Breath		
Artificial Joints (Hip/Knee)			High/Low Blood Pressure			Steroid Therapy		
Cancer			Kidney Disease			Stroke		
Diabetes			Liver Disease			Tuberculosis		
Epilepsy			Tuberculosis			Excessive Bleeding		
Heart Disease/Disorder			Radiation Therapy to head or neck			Nervous/Anxiety Conditions		
Bone disease, including osteoporosis			Anaemia, leukaemia or other blood diseases			Bronchitis, emphysema or other lung diseases		

Any other condition(s) not mentioned above:

Please fill the next page……

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PATIENT DENTAL HISTORY

What dental problems if any, do you have? (Please tick)

	Y	N		Y	N
Toothache			Sensitive teeth		
Bleeding gums			Loose teeth		
Unsatisfactory dentures			Rapidly decaying teeth		
Lost filing – cavity			Grinding clenching of teeth		
Worn/broken teeth			Pain in face or jaw joints		
Sounds/clicking from jaw			Difficulty/discomfort when chewing		
Discoloured teeth/filings			Bad breath		

Have you had orthodontic treatments?		
Do you wear a night guard/splint?		
When was your last dental appointment?		

Is there anything you would like to change about your smile?

As we like to thank current patients or other healthcare providers for their kind referrals, if you were referred, please provide the name of the person who referred you:

How did you hear about our practice? Please circle:

Signage / Google / Web (other) / Flyer / Yellow Pages Online / Advertisement / Event / Local Resident / Friend
Other (Please specify):

Your / Guardian's signature: Date:

Dentist's signature: