KEDRON FAMILY DENTAL

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Smile With Confidence

MEDICAL HISTORY

Title: _____Patient Name:_____

DOB: ___/___/____ Email Address: _____

Street Address: _____Suburb: _____Post code: _____

Home phone: _____Business: _____ Mobile: _____

Private Medical Fund: YES / NO Fund: _____ Referred by: Friend/ Internet / Other

Emergency contact:_____ Phone No._____

Please tick if you have had any of the following:

- I have confidential medical information that I do not wish to write down. I prefer to speak to the dental clinician about this.

Anaemia		Immune problems	
Angina		Irritable bowel syndrome	
Arthritis (Rheumatoid / Osteo)		Jaundice	
Asthma		Joint replacement	
Cancer, Radium therapy, Chemo therapy		Kidney disease	
Steroid Therapy		Low blood pressure	
Depression		Osteoporosis	
Diabetes		Persistent cough	
Epilepsy		Sinus trouble	
Glaucoma		Skin condition (Eczema, Psoriasis)	
Heart attack / surgery/pacemaker		Sleep apnoea	
Heart defects /murmur		Stroke	
Hepatitis A B or C		Thyroid problems	
High blood pressure		TMD / Treatment	
HIV		Excessive bleeding	
Ulcers – mouth		Ulcers stomach	
Rheumatic fever		Tuberculosis	
Nervous or psychiatric condition		Prosthetic implant eg hip	

Other: _____

If pregnant, how far along are you?_____ Do you smoke? No /Yes If yes, How many a day? ____

Have you been hospitalised in the past 12mths? Yes/No _____

Do you have any know **allergies**? No/Yes (list) _____

Are you currently taking **medication/ vitamins**? No/ Yes (list) _____

_____-___

Medical Practitioner _____ Phone Number_____

PLEASE TICK

	YES	NO
Have the tonsils been removed? If so what age?		
Have the adenoids been removed? If so what age?		
Do you have jaw, clicking or pain?		
Do you have frequent headaches, especially when you wake?		
Has there ever been an injury to the face or mouth?		
Have you ever sucked your thumb or fingers? If so until what age?		
Do you have any speech problems?		
Do you breathe through your mouth?		
While sleeping, do you breathe through your mouth or nose?	nose	mouth
Do you snore or make noises when sleeping?		
Did you have a lot of colds when young?		
Do you clench or grind your teeth?		
Do you wake up tired?		
Do you wake up with a tender jaw?		
Do you have dry mouth?		
Do you suffer from bad breathe?		
Are you happy with the appearance of your teeth?		

Please list any problems/concerns that you have with your teeth/mouth:_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I have read and accept the privacy policy.

_____ _____

Signature of patient, parent or guardian Date