

# Patient information

## Medical History



### Patient Details

Title	If other, please list					Date of birth
Miss	Ms	Mrs	Mr	Dr	Other	<input type="text"/>
Surname	Given names				Preferred name	
Address					Postcode	
					Occupation	
Mobile	Preferred contact number		Email address			
Are you with a health fund?	Name of fund		Under 18yrs: is your child eligible for free dental care with Medicare?			
Yes	No		Yes	No	Unsure	

### Emergency Contact

Name	Relationship	Contact number
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### Other Information

Do other family members attend this surgery?	If you wish to link your files, please provide full name/s
Yes	No

If so, do you wish to link your files together?

Yes      No

How did you hear about our surgery?

How would you like to be reminded about future dental checkups?

Email      SMS      Telephone      Post      I don't want reminders

*Continued over page >*

### Medical Information

Name of your doctor / Medical practice

Phone

Address (if known)

### Bone Density Medications

Have you ever taken, or are you scheduled to begin taking a bone antiresorptive agent (like Prolia, Fosamax, Actonel, Atelvia, Boniva, Reclast) for low bone density, osteoporosis or Paget's disease?

Yes

No

Unsure

Have you ever been treated, or are you scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcaemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

Yes

No

Unsure

### Joint Replacement

Have you had orthopaedic total joint (hip, knee, elbow) replacement?    Approximate date

Yes

No

If yes, did you have any complications?

### Bleeding Disorders / Blood Thinners

Are you taking any antithrombotic medication (bloodthinners)?

Aspirin

Warfarin

Plavix

Eliquis

Xarelto

Other, please list

Do you have a genetic or acquired bleeding disorder?

If yes, please provide details

Yes

No

### Cardiac Conditions

Please tick if you've experienced any of the following

Artificial (prosthetic) heart valve

Yes

No

Previous infective endocarditis

Yes

No

Surgery for cardiac valve repair

Yes

No

Congenital heart disease (CHD)

Yes

No

Rheumatic heart disease

Yes

No

Unrepaired, cyanotic CHD

Yes

No

If yes, do you have Indigenous Australian or Torres Strait Islander heritage?

Yes

No

Repaired (completely) in last 6 months

Yes

No

Repaired CHD with residual defects

Yes

No

*Continued over page >*

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### Medical Information (continued)

#### Allergies

Are you allergic to or have you had a reaction to

Local anaesthetics	Yes	No	Sulphur drugs	Yes	No	Other allergies
Latex	Yes	No	Other antibiotics	Yes	No	
Penicillin	Yes	No	<input type="radio"/> Type			

#### Medication

Are you taking or have you recently taken any prescription or over the counter medicine? Yes      No

If yes, please list all (or bring a list of medications to your dental appointment)

#### Women Only

Are you pregnant? If yes, how many weeks? Are you nursing?  
Yes      No Yes      No

#### General Medical Conditions

Cardiovascular disease	Cancer therapy / Chemotherapy / Radiation	Hepatitis, jaundice or liver disease
Angina	Pacemaker / Defibrillator	Kidney problems
Asthma	G.E Reflux / Persistent heartburn	Osteoporosis
High blood pressure	Autoimmune disease	Epilepsy
Low blood pressure	Thyroid problems	Are you a smoker?
Diabetes	HIV / AIDS	Yes      No

Do you have any disease, condition or problem not listed that you think we should know about?

*Continued over page >*

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### Consent

I acknowledge that the information given on this form is true and accurate to the best of my knowledge. It is my responsibility to inform the dentist of any changes in my medical status.

Patient / Guardian name

Patient / Guardian signature

Date

### Send your form back to us

Once you have finished filling in your form, check all details are completed.  
Click the upload button to the left to forward your form to us.

### For completion by dentist

Comments

### Privacy statement

Daisy Hill Dental Care collects and maintains this information in the form of a medical history in order to provide safe and successful dental treatment. The above information and any additional information required will only be used by the people involved in providing your dental care.

We will only use your information for the purpose it was collected, other than those rare circumstances where it is necessary in the interests of public health and safety or law enforcement.