MEDICAL/DENTAL HISTORY

Yandina Dental

It is important to know details about your medical history as this can affect the success of your dental treatment and how we can provide this treatment safely for you. The information you provide is strictly confidential.

Title (eg Mr/Mrs/Ms):	Last Name:	
Date of Birth:	First Name(s):	
Home address:		
Mobile:	Home:	Work:
Email address:	Please tick if you wish to opt out of practice emails ☐	
How did you find out about our practice?:		
Who is your medical practitioner:	Phone number:	Health fund:
I have confidential medical information that I do not wish to write down, I would prefer to speak to a dentist about this (please tick box) ☐		

	YES	NO	DETAILS
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?			
Are you taking any prescription (or other) medications at present?			
Have you been hospitalised in the last 12 months?			
Have you or anyone in your household returned from overseas travel in the last 10 days?			

Please list any current medications:
Please list any drugs or medicines you are allergic to:
Please list any other known allergies (including latex, food and preservatives):

DO YOU HAVE NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

(Please tick appropriate box)

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Steroid therapy			Kidney disease			Radiotherapy		
Rheumatic fever			Excessive bleeding			Cardiac pacemaker		
Epilepsy			Stroke			Stomach or digestive condition		
Asthma			Cancer			Hepatitis or other liver disease		
Diabetes Type 1/Type 2			Thyroid disease			Contact with blood-borne viruses		
Bone disorder including osteoporosis			Prosthetic implant eg. artificial hip			Bronchitis, emphysema or other lung diseases		
Heart disorder/complaint			Anaemia/leukaemia			Other blood disorders		
Anxiety/depression			High/low blood pressure (Please circle)			Orthodontics/oral surgery		
Snoring/sleep apnoea			Headaches/jaw pain			Tooth grinding		

Do you wake up feeling tired and feel like you haven't had a good night sleep? (please circle) Yes No

Are you interested in cosmetic injections? (please circle) Yes No

Are you interested in tooth whitening/bleaching? (please circle) Yes No

Are you playing any contact sport, if yes which sport?:

Please list any other conditions not mentioned:

When was your last dental examination?:

Who was your previous Dentist?:

PLEASE LIST ANY CONCERNS OR PROBLEMS THAT YOU HAVE WITH YOUR TEETH OR MOUTH

How do you wish to be contacted for confirmation/reminders and recalls?

Email ☐ SMS ☐ Phone Call ☐

Patient signature (or parent/guardian if under 16):	Date: