

## Medical History Questionnaire

Welcome to Canberra Dental Care. Please complete this form as accurately as possible to assist us in providing the best dental care for you. If you have any questions please do not hesitate to ask one of our staff at reception. All information provided will be treated with complete professional confidentiality.

FULL NAME (Mr, Mrs, Miss, Ms, Dr).....

ADDRESS:.....

SUBURB:..... POSTCODE:..... DATE OF BIRTH: ...../...../.....

TELEPHONE: (Home)..... (Work)..... (Mobile).....

EMAIL ADDRESS: .....

WHO REFERRED YOU? (e.g. friend, google, previous dentist): .....

HEALTHFUND: ..... LAST DENTAL VISIT: .....

REASON FOR YOUR VISIT TODAY? .....

(e.g. toothache, check up, scale and clean, appearance of your teeth)

Past / Current Medical Conditions				Current Medications (prescription, Over the counter, herbal)	
	No	Yes		No	Yes
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Intellectually Disabled	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Physically Disabled	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Radiotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Smoker	<input type="checkbox"/>	<input type="checkbox"/>
Gastro Intestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Bypass	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve Problem	<input type="checkbox"/>	<input type="checkbox"/>	Are you Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

  

Allergies	
<input type="checkbox"/> Nil Known	
<input type="checkbox"/> Yes - Details	

  

Infectious History	
<input type="checkbox"/> Nil Known	
<input type="checkbox"/> Yes - Details	

  

Other Relevant Details / Conditions	
<input type="checkbox"/> Nil Known	
<input type="checkbox"/> Yes - Details	

  

Recent Hospitalisation / Surgery	
<input type="checkbox"/> Nil Known	
<input type="checkbox"/> Yes - Details	

I agree that the above is a true and accurate record. I understand that Canberra Dental Care requires payment on the day of treatment. Any expenses, costs or disbursements incurred by Canberra Dental Care in recovering any outstanding monies including debt collection fees and legal costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may also result in a deposit requirement prior to future appointments being scheduled.

SIGNATURE: ..... DATE: ..... / ..... / .....