**LOGO** Element Dental

1.02/200 Central Coast Hwy

Erina NSW 2250

(02) 43 677 677

**CONFIDENTIAL MEDICAL HISTORY**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title First Middle Last

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Work Home

Emergency Contact Person:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General Practitioner:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a health fund with dental cover? Yes or No

If so, what is the name of the fund?

Fund Number?

Priority Number on card: 0 1 2 3 4 5

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referrred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate if you are allergic to any of the following ?**

Aspirin  Codeine  Penicillin  Sulfites  Latex  Local Anaesthetic  Lactose  Nickel 

Other:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently taking, or have ever taken, any of the following medication?**

Asthma inhaler  Anti-epileptics  Anti-depressants  Blood Pressure  Blood Thinners  Bisphosphonates  Chemotherapy  Insulin  Immunosuppressants  Steroids  Oral Contraceptive  Other 

**Please specify medication name, dose, and frequency where possible:**

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**Do you require antibiotic cover?**  Yes  No 

**Have you had a joint replacement?** Yes  No 

**Women:**

**Are you pregnant?** Yes  No  Possible  or **Breast Feeding?** Yes  No 

**Please Turnover**

**Do you have, or have you had, any of the following?**

**Dental**

Acid Reflux Yes  No 

Bad Breath/Taste Yes  No 

Bleeding/Swollen/Sore Gums Yes  No 

Blisters/Ulcers in Mouth Yes  No 

Broken tooth/filling Yes  No 

Burning tongue Yes  No 

Dry mouth Yes  No 

Food collection between teeth Yes  No 

Grinding/clenching teeth (day/night) Yes  No 

Loose teeth Yes  No 

Crooked teeth Yes  No 

Discoloured teeth Yes  No 

Sensitivity to Hot/Cold Yes  No 

Tooth pain when chewing Yes  No 

Jaw pain/Fracture Yes  No 

Orthodontic treatment/history Yes  No 

Oral Cancer Yes  No 

**Diet/Lifestyle**

Drink more than one glass alcohol per day Yes  No 

Smoking Yes  No 

Carbonated drinks Yes  No 

Sugary foods Yes  No 

**Blood**

Anaemia Yes  No 

Blood clots Yes  No 

Leukemia Yes  No 

Low platelets Yes  No 

Lymphoma Yes  No 

Haemophelia Yes  No 

**Chest**

Bronchitis Yes  No 

Cystic Fibrosis Yes  No 

Emphysema Yes  No 

Pneumonia Yes  No 

**Infectious Disease**

Creutzfeldt-Jakob Disease Yes  No 

Hepatitis A,B,C,D Yes  No 

HIV/AIDS Yes  No 

Influenza Yes  No 

Shingles Yes  No 

Tuberculosis Yes  No 

**Heart**

Angina Yes  No 

Atrial Fibrillation Yes  No 

Blood Pressure (High/Low) Yes  No 

Congenital Heart Disease Yes  No 

Heart attack Yes  No 

Heart murmur Yes  No 

Heart surgery Yes  No 

Heart valve replacement Yes  No 

Infective endocarditis Yes  No 

Rheumatic Heart Disease Yes  No 

Pacemaker Yes  No 

Stent Yes  No 

**Other**

Anxiety/PTSD Yes  No 

Arthritis Yes  No 

Alzheimer’s Yes  No 

Asthma Yes  No 

Anaphylaxis Yes  No 

Auto-immune disease Yes  No 

Coeliac Yes  No 

Depression Yes  No 

Diabetes Yes  No 

Epilepsy Yes  No 

Kidney Disease Yes  No 

Liver Disease Yes  No 

Osteoporosis Yes  No 

Parkinson’s Yes  No 

Radiation to Head/Neck Yes  No 

Schizophrenia Yes  No 

Snoring Yes  No 

Sleep apnea Yes  No 

Stroke Yes  No 

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Thank you for the time to complete your medical history form.*

*Oral health is linked to overall health and this comprehensive questionnaire will help us to provide you with optimal and safe care.*