

MEDICAL HISTORY FORM



Dental Solutions

Medical Details:

Information about your dental history:

When was your last Dental Treatment Approximately? _____

Last dental cleaning? _____ Last full mouth x-rays? _____

Do you feel nervous about your dental treatment? _____

Are you currently undergoing any medical treatment Yes / No

Physician's / Surgery Name _____ Phone # _____

Are you taking any medication, drugs or pills now? Yes / No

If yes, name medication and dosage: _____

Are you taking any Biphosphonate medications? Eg: Aledronate, Risedronate, Disodium Pamidronate, Other?

Do you have any allergies? Eg: Penicillin, Aspirin, Erythromycin, other? _____

Are you pregnant or nursing? _____

Please indicate below if you have had, or have at present. Any of the following Circle 'yes' or 'no'

Stroke	Y / N	Stomach Ulcers	Y / N
Chest Pain	Y / N	Thyroid Problems	Y / N
Congenital Heart Disease	Y / N	Diabetes	Y / N
Artificial Joints (hip, knee)	Y / N	Smoker	Y / N
Artificial Heart Valve	Y / N	Tuberculosis	Y / N
Radiation/Chemotherapy	Y / N	Haemophilia	Y / N
Mitral Valve Prolapses	Y / N	Emphysema / Chronic Cough	Y / N
Diet (Special/Restricted)	Y / N	Heart (Surgery, Disease, Attack)	Y / N
High Blood Pressure	Y / N	Latex Sensitivity	Y / N
Arthritis / Rheumatism	Y / N	CJD	Y / N
Heart Murmur	Y / N	Asthma	Y / N
Fainting / Dizzy Spells	Y / N	Hay Fever	Y / N
Heart Pacemaker	Y / N	Hepatitis A B C	Y / N
Sinus Troubles	Y / N	Epilepsy	Y / N
Rheumatic Fever	Y / N	HIV / AIDS	Y / N
Bone Disease (Osteoporosis, Paget's Disease, Cancer spread to the bone, Multiple Myeloma)	Y / N		

Would you like to change your smile? Yes / No

If so, what would you like to change? Colour / straighter / shape / close gaps? _____

A Broken appointment is a loss to everyone. It is Dental Solutions's policy that a cancellation fee will apply if you cancel within 24-hours of your confirmed appointment. (Please tick)

I understand that all treatment is to be paid for on the day of treatment and all information collected will be treated in confidence. (Please tick)

Do you want to receive marketing information about Dental Solutions (Please tick)

Patient / Guardian Signature _____ Date _____