dalby family dental

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ABN: 57 809 695 046

Medical History

TITLE: FIRST NAME: SURNAME:

DOB: ADDRESS:

PHONE: HEALTH FUND & NUMBER:

EMAIL: EMERGENCY CONTACT:

EMERGENCY CONTACT RELATIONSHIP: PHONE:

Please indicate yes or no for the following:

Do you require antibiotics prior to dental treatment? **Y / N** Details:

Have you ever had a reaction to anaesthetic? **Y / N** Details:

Are you a **Smoker / Exsmoker**? Details:

Are you pregnant or trying? **Y / N** Details:

Have you been hospitalised in the last 12 months? **Y / N** Details:

Have you had a serious illness in the last 10yrs? **Y / N** Details:

Are you currently being treated by a doctor? **Y / N** Details:

Please list all allergies:

Please list all current medications:

DOCTOR: PHONE:

Do you have any of the following medical conditions?

Anaemia	Y	N	Excessive Bleeder	Y	N	Radiation	Y	N	Blood Disease	Y	N
Hepatitis	Y	N	Rheumatic Fever	Y	N	Osteoporosis	Y	N	HIV	Y	N
Reflux	Y	N	Bone Disease	Y	N	Heart Surgery	Y	N	Digestive Issues	Y	N
Bronchitis	Y	N	Heart Defects	Y	N	Sinus	Y	N	Emphysema	Y	N
High B/P	Y	N	Low B/P	Y	N	Steroid Therapy	Y	N	Lung Disease	Y	N
Stroke	Y	N	Cancer	Y	N	Artificial Joint	Y	N	Tuberculosis	Y	N
Diabetes T1/T2	Y	N	Kidney Disease	Y	N	Asthma	Y	N	Epilepsy	Y	N
Pacemaker:	Y	N	Other	Y	N						

Do you drink sports or energy drinks? **Y / N** How did you hear of the practice?

Your / Guardian Signature: Date: