DimosDental

Medical History Update

Title:_____ Surname:_____

Given Name(s): _____D.O.B:_____

Marital Status:_____

Partners Name:_____

Residential Address: _____

Suburb: _____Post Code: _____Home Phone: _____

Occupation: _____Employer: _____

Business Address: _____

Suburb: _____Post Code: _____ Work Phone: _____

E-Mail: _____Mobile Phone: _____

Confidential Medical History

The thoroughness of this medical history is designed for your safety. Your complete and honest answers will assist us in treating you with consideration for your individual needs.

The name of your Doctor/Healthcare provider: _____

Are you currently receiving medical attention? ☐ Yes ☐ No If so, for what reason? _____

_____

Are you currently taking any medication? ☐ Yes ☐ No If so, please list: _____

_____

Have you had a medical examination in the past 12 months? ☐ Yes ☐ No If so, for what reason?

_____

Do you or have you ever suffered from any of the following?

Anaemia	Y	N	Hepatitis / Jaundice / HIV	Y	N	Osteoporosis	Y	N
Anxiety / Depression	Y	N	Heart Problems	Y	N	Prosthetic Joint(s)	Y	N
Arthritis	Y	N	Heart Attack / Angina	Y	N	Rheumatic Fever	Y	N
Asthma	Y	N	Heart Murmur	Y	N	Tumour History	Y	N
Bleeding Disorders	Y	N	Heart Valve (prosthetic)	Y	N	Radiation Therapy	Y	N
Blood Pressure (High)	Y	N	Cardiac Pacemaker	Y	N	Chemo-Therapy	Y	N
Bone Disorders	Y	N	Kidney Disease	Y	N	Sinus Problems	Y	N
Diabetes	Y	N	Liver Disease	Y	N	Tuberculosis	Y	N
Auto-Immune Disorder	Y	N	Neuro-Muscular Disorder	Y	N	Currently taking Antibiotics	Y	N

Do you have allergies to any of the following?

Penicillin Y N Latex Y N Local Anaesthetic Y N Other Medications: Y N

Please list:_____

Do you smoke? ☐ Yes ☐ No If so, how many packs per week? _____

Are you pregnant? ☐ Yes ☐ No ☐ Maybe? ☐ Not Applicable

Do you suffer from chronic or frequent: Headaches ☐ Yes ☐ No

Jaw Pain or Earache ☐ Yes ☐ No

Neck/Shoulder Pain ☐ Yes ☐ No

Are you happy with your smile? ☐ Yes ☐ No

Have you ever had: Facial Aesthetic Treatment? ☐ Yes ☐ No

BOTOX® or DYSPORT®? ☐ Yes ☐ No

Dermal Fillers? ☐ Yes ☐ No

Other? …… ☐ Yes ☐ No

Signature:_____ Date:_____