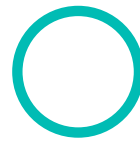


# Update

## Medical and dental history



thedentalpractice

Date:

### Patient details

In order for us to maintain up to date records, please provide your contact details below.

Surname: \_\_\_\_\_ Given name: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
Residential address: \_\_\_\_\_  
Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Mobile: \_\_\_\_\_  
Email: \_\_\_\_\_  
Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_  
Private health insurer: \_\_\_\_\_ Member #: \_\_\_\_\_ Patient #: \_\_\_\_\_

GP name: \_\_\_\_\_ GP phone: \_\_\_\_\_  
GP address: \_\_\_\_\_

### Medical history

Have there been any changes to the following? If so, please tick the appropriate boxes.

Abnormal/excessive bleeding	Cardiac surgery/pacemaker	Prosthetic joints
Angina	Congenital heart defect	Psychiatric care
Artificial heart valve	Diabetes type 1/type 2	Radiation/chemotherapy
Asthma	Epilepsy	Reflux
Blood disorder (name below)	Heart disease	Rheumatic fever
	Heart murmur	Steroid therapy
Blood pressure (high/low)	Hepatitis A/B/C/D	Stroke
Blood thinner	HIV positive	Thyroid disorder
Bone disease (e.g. Osteoporosis)	Immune deficiency	Other condition (name below)
Current or past	Kidney/liver disease	
Bisphosphonate therapy	Neurological disorder	
Cancer	Oral ulceration	

Are you pregnant?    Yes    No    If so, due date?

Any new allergies? If so, please list:

Are you taking medication (including natural supplements)? If so, please list:

Patient/Legal guardian name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OFFICE USE ONLY.

Form checked by \_\_\_\_\_ Data keyed by \_\_\_\_\_ Keying checked by \_\_\_\_\_ Form scanned by \_\_\_\_\_