

## HEALTH HISTORY FORM

Dr/Mr/Mrs/Miss/Ms First Name(s): \_\_\_\_\_ Surname \_\_\_\_\_

Address: \_\_\_\_\_ Suburb: \_\_\_\_\_ Postcode: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Tel (Home): \_\_\_\_\_ Tel (Mobile): \_\_\_\_\_

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

Contact in case of emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_ Tel: \_\_\_\_\_

Are you in a Private Health Fund? Yes / No Fund Name: \_\_\_\_\_

Member No: \_\_\_\_\_ Reference on Card (# next to name): \_\_\_\_\_

How did you find us? (e.g. google, letter drop, referral etc) \_\_\_\_\_

If referred, who referred you? \_\_\_\_\_

### DENTAL HISTORY

What is the purpose of your visit? \_\_\_\_\_

Do you have any specific concerns? \_\_\_\_\_

When was your last dental examination? \_\_\_\_\_

Are you happy with the appearance of your teeth? \_\_\_\_\_

Have you had any previous problems with dental treatment? \_\_\_\_\_

Are you concerned with crowding or crooked teeth? \_\_\_\_\_

Do you have any issues sleeping, tiredness or snoring? \_\_\_\_\_

Do you have any history of sleep apnoea or CPAP use? \_\_\_\_\_

### MEDICAL HISTORY

Name of Medical GP: \_\_\_\_\_ Clinic: \_\_\_\_\_

Are you taking any Medications presently: (if yes, please list): \_\_\_\_\_

Do you have any Allergies: (e.g. Penicillin, Latex, Codeine) (if yes please list): \_\_\_\_\_

**Please indicate below if you have had, or have at present, any of the following:** *(please tick)*

- |  |  |
|--|--|
| <input type="checkbox"/> High Blood Pressure                 | <input type="checkbox"/> Diabetes                              |
| <input type="checkbox"/> Heart Ailment                       | <input type="checkbox"/> Thyroid Problems                      |
| <input type="checkbox"/> Rheumatic Fever                     | <input type="checkbox"/> Excessive Bleeding or Blood Disorders |
| <input type="checkbox"/> Asthma, Chest or Breathing Problems | <input type="checkbox"/> Epilepsy                              |
| <input type="checkbox"/> Tuberculosis                        | <input type="checkbox"/> Hepatitis                             |
| <input type="checkbox"/> Stomach or Bowel Problems           | <input type="checkbox"/> AIDS/HIV                              |
| <input type="checkbox"/> Kidney Disease                      | <input type="checkbox"/> Bone Disorders or Diseases            |
| <input type="checkbox"/> Prosthetic Valves/Hip/Implants      | <input type="checkbox"/> Radiation or Chemotherapy             |

**Do you smoke:** Yes / No

**Females only** Are You Pregnant: Yes / No

Are You Nursing: Yes / No

Other *(please describe)*: \_\_\_\_\_

I understand that all treatment is to be paid for on the day of treatment as no credit is given. I understand that notes, radiographs (x-rays) or models related to treatment may be sent to other dental practitioners to aid in treatment and consent to this. I also give permission for the practice to use the above contact details to send me appointment and check-up reminders.

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

Patient / Parent / Guardian (please circle)