endodontic group

MEDICAL HISTORY FORM | Welcome to our Practice

Your medical history can affect the success of your dental treatment and will guide us on how to provide safe treatment for you. The information you provide is completely confidential and will be handled in accordance with our Privacy Policy & Charter of Patient Rights (attached or on our website).

PATIENT DETAILS

Title (eg Mr/s, Ms, Mx, Dr, Rev) _____ First name _____ Last name _____

Preferred name _____ Date of birth _____ Gender *(please circle)* **M / F / Other**

Address _____ Occupation _____

Suburb _____ State _____ Post code _____

Phone (Home) _____ (Work) _____ (Mob) _____

Email _____

Who referred you to this practice? _____

Emergency contact person Phone number Relationship

_____

Do you have private health insurance with dental benefits? **YES / NO** *If yes, which fund:* _____

Are you a DVA (Dept. of Veterans Affairs) Gold Card holder? **YES / NO** DVA card number: _____

CONFIDENTIAL MEDICAL HISTORY

If you prefer to discuss your medical information privately with the endodontist please ✓ this box ☐

Have you ever had or do you currently have:			
Asthma	**Y / N**	High blood pressure	**Y / N**
Bleeding disorder	**Y / N**		
Cancer *If yes, please state:* *> which type of cancer* *> how long ago it was diagnosed* *> treatment you have had, eg radiation, chemotherapy, immunotherapy*	**Y / N**	Hip or joint replacement *If yes, please state:* *> which type of replacement* *> year of replacement*	**Y / N**
		Kidney disease/Transplant	**Y / N**
Diabetes	**Y / N**	Liver disease/Transplant	**Y / N**
Epilepsy	**Y / N**	Rheumatic fever	**Y / N**
Heart condition/Heart valve problem/Pacemaker - *If yes, please provide details*	**Y / N**	Any other serious illness or disability, eg rheumatoid arthritis, osteoporosis, autoimmune disease, etc *If yes, please state which illness/disability*	**Y / N**
Do you currently have, or have you had in the past 4 weeks, any viral or bacterial infections or symptoms, including fever, cough, sore throat, difficulty breathing, COVID-19, influenza, shingles, cold sores? *If yes, please provide details or describe your symptoms.*			**Y / N**

Have you ever had, or are you a known carrier of, any other infectious disease, including hepatitis, HIV/AIDS? *If yes, please provide details*			**Y / N**
Are you being treated for any other conditions by other health practitioners? *If yes, please state what conditions & treatments*			**Y / N**
Do you smoke? - *If yes, how many per day and for how many years*	**Y / N**	Do you drink alcohol?	**Y / N**
LADIES Is there a possibility that you are pregnant? *If yes, how many weeks?*			**Y / N**
Note: *As many medicines may influence the effectiveness of hormonal contraception, please advise your Endodontist if this is relevant in your case.*			

MEDICATIONS

Are you currently taking any medications? **YES / NO**

If YES, *please list any medications you may be taking* (including herbal remedies, vitamins, supplements, cold/flu treatments, sleeping pills, pain relievers, injections, implants or contraceptives), so we can take appropriate precautions and avoid drug interactions. If you need additional space, please ask at reception for more paper.

DRUG NAME	DOSE	DURATION OF TREATMENT	PURPOSE

ALLERGIES

Do you have any known ALLERGIES or ADVERSE REACTIONS to drugs (especially antibiotics eg. penicillin), medicines, antiseptics, local anaesthetics, preservatives or latex that we should know about? **YES / NO** *If yes, please state:*

DRUG NAME	NATURE OF REACTION	HOW LONG AGO

SIGNED _____ **DATED** _____

Please scan or photograph completed form and email to **brisbane@endodonticgroup.com.au**