BAYVIEW DENTAL CENTRE

141 BAYVIEW STREET, RUNAWAY BAY

MEDICAL HISTORY

TITLE:…… SURNAME:.....FIRST NAME:.....PREFERRED.....

DATE OF BIRTH:...../...../.....EMAIL:.....

ADDRESS:.....SUBURB.....P/C.....

HOME PH:.....BUSINESS PH:.....MOBILE.....

OCCUPATION:..... HOW DID YOU HEAR ABOUT US?.....

DO YOU BELONG TO A DENTAL HEALTH FUND? YES/NO WHICH ONE?.....

MEDICAL HISTORY: *please indicate which of the following you have had, or have at present;*

☐ Rheumatic Heart Disorder	☐ Asthma	☐ Artificial Heart Valve
☐ Heart (Surgery, Disease, Attack)	☐ Diabetes type1 type2	☐ Pacemaker
☐ Epilepsy	☐ History of Tuberculosis	☐ Latex Sensitivity
☐ Hepatitis A, B or C	☐ High Blood Pressure	☐ Sinus Trouble
☐ Kidney Trouble	☐ Low Blood Pressure	☐ Ulcers
☐ Thyroid Problems	☐ Joint Replacement	☐ Contact Lenses
☐ Hay Fever, Allergies or Hives	☐ Chemo/Radiation Therapy	☐ Fainting/ Dizzy
☐ Nervous/Anxiousness	☐ Haemophilia	☐ Snore/Mouth Breathe
☐ Stroke	☐ Arthritis/Rheumatism	☐Other ……
☐ HIV or AIDS	☐ any blood borne virus/disease	

Are you at present or have you received medical treatment in the last 2 years? YES/NO

If Yes, please detail.....

What Medications (if any) are you currently taking, and Name of Regular Medical Doctor?

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Do you require Antibiotic Cover for your dental appointments? YES/NO ……

Ladies, are you pregnant? YES/NO

Do you have any drug allergies and/or Reactions? YES/NO.....

Do you Smoke? YES/NO/REFORMED

Have you ever taken/currently on Fosamax/Prolia or Osteoporosis related Medications? YES/NO

What is the reason for your appointment today?

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The information you have provided is strictly confidential and exclusive for our records only.

I understand that failure to complete the medical information may place myself and others at medical risk.

Patient Signature:..... Date:.....

Dentist Signature …….. Date:……