

Title	First Name	Surname
Health Card Number	Email	
Date of birth	Occupation	Employer
Address		Referred By
.....		Postal Code
Tel Contact	Home:	Work:
	Mobile:	
Emergency Contact	Emergency Contact Number	

Are you being treated for any medical conditions at the present time or have been treated within the last year? Yes No Not Sure

If so, why? _____

When was your last medical check-up? _____

Have there been any changes in your general health in the last year? Yes No Not Sure

If yes, please explain _____

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? Yes No Not Sure

If yes, please list _____

Do you have any allergies? If you answered yes, please list using the categories below: Yes No Not Sure

Medications _____

Latex/Rubber Products _____

Other (e.g. Hayfever, Foods) _____

Have you ever had an uncommon or adverse reaction to any medicines or injections? Yes No Not Sure

If yes, please explain _____

Do you have or have you ever had asthma? Yes No Not Sure

Do you have or have you ever had any heart or blood pressure problems? Yes No Not Sure

Do you have or have ever had a replacement or repair of a heart valve, an infection of the heart(i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? Yes No Not Sure

Have you ever had hepatitis, jaundice or liver disease? Yes No Not Sure

Which type of hepatitis? _____

Do you have a prosthetic or an artificial joint? Yes No Not Sure

If yes, please explain _____

Do you have a bleeding problem or a bleeding disorder? Yes No Not Sure

If yes, please explain _____

Have you ever been hospitalized for any illness or operations?

Yes No Not Sure

If yes, please explain _____

Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?

Yes No Not Sure

Do you have or have you ever had any of the following? Please Check

<input type="checkbox"/> Alzheimers	<input type="checkbox"/> Digestive Disorders / Acid Reflux	<input type="checkbox"/> Hypo/Hyperglycemia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Angina	<input type="checkbox"/> Drug / Alcohol Dependency	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Sexually Transmitted Infection
<input type="checkbox"/> Anemia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Lupus	<input type="checkbox"/> Steroid Therapy
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Migraine	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Head/Neck Injury	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Osteoporosis Medications (e.g. Fosamax, Actonel)	<input type="checkbox"/> Thrush
<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Diabetes Type 1	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Parkinsons Disease	<input type="checkbox"/> TMJ Disorder
<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Hodgkins Disease	<input type="checkbox"/> Radiation/Chemotherapy	<input type="checkbox"/> Tuberculosis

Are there any conditions or disease not listed above that you have or have had?

Yes No Not Sure

If yes, please list _____

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)

Yes No Not Sure

If yes, please explain _____

Do you smoke or chew tobacco products?

Yes No Not Sure

Are you nervous during dental treatment?

Yes No Not Sure

If yes, please explain _____

Hygienist _____

Tel _____

Address _____

The Information I have given above is true to the best of my knowledge

Patient Signature _____

Date _____

