Health History Form

WELCOME TO DUNCRAIG DENTAL CARE…

Please answer these questions as completely as possible to enable us to provide the best dental treatment for you.

Mr/ Mrs/Miss/Ms/ Dr/Master **Surname:**	**First name:**
Date of Birth:	**Address:**
Mobile:	**Postcode:**
Home phone:	**Work phone:**
Email:	**Occupation:**
Name of person responsible for fees, if not self:	**Address for account:**
Name of medical practitioner:	**Health fund:**
Emergency Contact Person:	**Emergency contact Phone number:**

Purpose of visit:_____ How did you hear about us?_____

List each Medication you are currently taking, with dosage:

Have you ever had any of the following?

Heart Problems	◯ Yes	◯ No	Reactions to anaesthetics	◯ Yes	◯ No
Blood Pressure issues High /Low	◯ Yes	◯ No	Allergies to medications	◯ Yes	◯ No
A Cardiac pacemaker	◯ Yes	◯ No	Allergy to any other substance	◯ Yes	◯ No
Circulatory problems	◯ Yes	◯ No	Liver or kidney problems	◯ Yes	◯ No
Blood Thinning medication	◯ Yes	◯ No	Osteoporosis treatment	◯ Yes	◯ No
Obstructive Sleep Apnoea	◯ Yes	◯ No	Anemia or other blood disorders	◯ Yes	◯ No
Rheumatic fever	◯ Yes	◯ No	Diabetes or family history or diabetes	◯ Yes	◯ No
Radiation or Cancer treatment	◯ Yes	◯ No	Asthma /Lung Conditions	◯ Yes	◯ No
Excessive bleeding/bruising	◯ Yes	◯ No	Hepatitis A, B, C, D or E	◯ Yes	◯ No
Stomach Ulcer/Reflux	◯ Yes	◯ No	Epilepsy	◯ Yes	◯ No
Sinus trouble	◯ Yes	◯ No	Are you pregnant	◯ Yes	◯ No
Joint Replacement Surgery	◯ Yes	◯ No	Due Date: _____		
Any current operations	◯ Yes	◯ No	Other medical condition	◯ Yes	◯ No
Details_____			Details_____		

Do you smoke? ◯ Yes ◯ No Or; have you smoked in the past? ◯ Yes ◯ No

If yes, how long have you smoked?_____ What do/did you Smoke?_____ How many per day?_____

Please answer the following:

Do your gums ever bleed when you brush?	◯ Yes	◯ No	Do you grind or clench your teeth?	◯ Yes	◯ No
Do you have occasional bad breath?	◯ Yes	◯ No	Does your jaw click or hurt?	◯ Yes	◯ No
Have you ever had gum disease?	◯ Yes	◯ No	Are you aware of biting your cheeks?	◯ Yes	◯ No
Have you had any teeth removed?	◯ Yes	◯ No	Do you snore/have trouble sleeping?	◯ Yes	◯ No
Have you had orthodontic treatment?	◯ Yes	◯ No	Do you suffer from daytime sleepiness?	◯ Yes	◯ No
Have you ever had a root canal therapy?	◯ Yes	◯ No	Does food get stuck between your teeth?	◯ Yes	◯ No
Do you have any crowns or bridges?	◯ Yes	◯ No	Are your teeth sensitive to hot/cold?	◯ Yes	◯ No
Do your teeth ever hurt when you bite hard?	◯ Yes	◯ No	Approximately how many fillings do you have? _____		

How long ago did you last visit a dentist? _____What was the purpose of that visit?_____

When did you last have dental x-rays taken? ◯ Less than a year ago ◯ Longer than a year ago

Please circle to indicate how apprehensive you are about having dental treatment:

NOT NERVOUS 1 2 3 4 5 6 7 8 9 10 VERY NERVOUS

If you are **nervous** are you interested in finding out more about our **sedation** options? _____

Consent for treatment

By signing this form I acknowledge that this represents an accurate medical history. I agree to advise the dentist of any changes to my medical history in the future. I authorise the dentist to discuss my clinical treatment with other medical and dental practitioners and specialists if needed. I understand this information may be viewed by other staff members of the practice and that all information will be treated with confidentiality under the guidelines of the Privacy Act of 2002.

Due to the high demand for appointments at Duncraig Dental Care, we have regrettably had to enforce a cancellation policy. Appointments that are unattended without two working days notice, will incur a fee. While we endeavor to confirm appointments two working days prior to the appointment, this may not always be possible. We appreciate your cooperation and look forward to providing you with excellent dental care.

Signed:_____ **Date:**_____

I authorise the use of anonymous images of my face to be used by the dentists at Duncraig Dental Care for educational and marketing purposes.

Signed:_____ **Date:**_____

Please sign and date when details have been corrected/amended.			

Office Use only	Date:	B.P	P
	Date:	B.P	P
	Date:	B.P	P
	Date:	B.P	P