HOLLAND PARK FAMILY DENTAL PRACTICE
– Updated Medical History Record

Your current state of health, previous medical conditions, and any past surgery can have important influences on the dental treatment that we provide. As such, you are requested to complete this medical history record.

Personal Details

Title:
First Name: Middle Name:
Surname: Date of Birth:
Home Address:
Suburb: State: Postcode:
Home Ph: Mobile Ph: Work Ph:
Email Address:

Are you in a health fund? Yes ☐ No ☐ Name of Fund:

Medical History

Are you currently under the care of a medical practitioner? Yes ☐ No ☐
Name of Doctor: Contact Ph:

Do you take any **medications**? (Prescription, over-the-counter, vitamin, or herbal)	Yes ☐	No ☐
Please list medications:		
Do you take 'blood thinning' (eg aspirin, warfarin, Plavix) medications?	Yes ☐	No ☐
Do you take any osteoporosis (eg Fosamax, Actonel) medications?	Yes ☐	No ☐
Do you require antibiotics prior to dental treatment? Reason:	Yes ☐	No ☐
Are you a **smoker**?	Yes ☐	No ☐
For Females, are you **pregnant**?	Yes ☐	No ☐

Do you have **allergies** to: Penicillin ☐ Sulphur ☐ Latex ☐ Codeine / Morphine ☐ Aspirin ☐
Other Allergies:

Have you ever had an adverse reaction to dental injections?	Yes ☐	No ☐
Have you ever suffered excessive bleeding following a cut or dental extraction?	Yes ☐	No ☐

Have you **ever** been diagnosed with any of the following conditions?

Rheumatic fever	Yes ☐	No ☐		Blood Pressure	High ☐ Low ☐	No ☐
Heart / Blood Vessel Surgery	Yes ☐	No ☐		Heart valve replacement	Yes ☐	No ☐
Pacemaker Fitted	Yes ☐	No ☐		Heart Murmur	Yes ☐	No ☐
Angina	Yes ☐	No ☐		Heart Attack	Yes ☐	No ☐
Emphysema	Yes ☐	No ☐		Chronic Bronchitis	Yes ☐	No ☐
Asthma	Yes ☐	No ☐		Prosthetic Joint eg knee, hip	Yes ☐	No ☐
Arthritis Rheumatoid ☐	Osteo- ☐	No ☐		Long-term steroid use	Yes ☐	No ☐
Stroke	Yes ☐	No ☐		Diabetes	Yes ☐	No ☐
Liver Disease	Yes ☐	No ☐		Kidney Disease	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐		Cancer	Yes ☐	No ☐
Radiotherapy	Yes ☐	No ☐		Thyroid Disease	Yes ☐	No ☐
Hepatitis A ☐ B ☐ C ☐		No ☐		HIV +	Yes ☐	No ☐

Please list other medical conditions:

I herby consent to the use of this information as set out in the Privacy & Consent Statement and agree to the Practice Payment Policy available for review at hollandparkdental.com.au
Patient / Parent / Guardian Name: **Date**: