MIDWAY DENTAL CLINIC

New Patient Health History Form

A healthy smile is always in style!

All questions contained in this questionnaire are strictly confidential and will become part of your medical and dental record.

Date (dd/mm/yyyy):

PERSONAL DETAILS

Last Name:

First Name:

Middle Name:

Date Of Birth: (dd/mm/yyyy)

CONTACT DETAILS

Mobile:

Home Tel:

Work Tel:

Email:

Address:

Suburb:

Postcode:

State:

PERSONAL MEDICAL & DENTAL HISTORY

		Yes	No
1.	Have you ever had heart trouble or high blood pressure?	O	O
2.	Have you ever had, or do you have hepatitis or HIV/AIDS?	O	O
3.	Have you ever had rheumatic fever/diabetes/hyperthyroidism/asthma/glaucoma/nervous disorders/anaemia/radiation treatment?	O	O
4.	Have you ever had any other serious illness?	O	O
5.	Are you currently under any medical treatment?	O	O
6.	Are you taking any drugs or medicines?	O	O
7.	Have you any known allergies to drugs (especially penicillin), medicines, and antiseptics?	O	O
8.	Have you ever had prolonged bleeding?	O	O
9.	Have you ever had a difficult tooth extraction?	O	O

10. (Women ONLY), If pregnant, state how many months?

11. List your regular GP/physician name and contact details:

Tel:

12. Are you covered by private health fund? If yes, List the fund name:

O Yes O No

Complete, Print & Sign OR Complete, Save & mailto: MidwayDentalClinic@gmail.com

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