



David Cox Dental Medical History

Title First Name Surname
DOB Health Fund
Address Phone Home
..... P Code Mobile
Employer Phone Work
GP's Name and Address

How did you hear about our practice?
If referred, by whom
Email address
How would you like your appointment confirmed?
Phone call SMS Email None

- 1. How is your general health?
- 2. Have you consulted a physician for any illness in the last 2yrs?
If yes, what was it for?
- 3. Are you currently taking, or have recently taken any prescription or
non-prescription medications?
If yes, please list
- 4. Have you been hospitalised in the last 2yrs?
If so, what was it for
- 5. Do you have any allergies to any drugs or medications?
Do you have an allergy to latex?
- 6. Do you bleed excessively when cut, bruise easily?
- 7. Are you currently taking or have taken cortisone / steroids?
- 8. Do you smoke or use other forms of tobacco?
- 9. WOMEN ONLY- Are you, or suspect you may be pregnant?

Do you have or have you ever had:

Heart Disease/Disorder Yes / No
Heart Surgery Yes / No
Rheumatic Fever Yes / No

Stroke Yes / No
Diabetes Yes / No
Recipient of human pituitary hormones
(growth hormones / gonadotrophins) Yes / No
Asthma Yes / No
Bronchitis Yes / No
Liver Disease Yes / No
Cancer Yes / No
Kidney Disease Yes / No
Arthritis Yes / No
Artificial Joints (Hip, Knee) Yes / No
Epilepsy Yes / No
Radiation Treatment to head
or neck Yes / No
Shortness of breath Yes / No
Hepatitis B/C Yes / No
HIV / Aids Yes / No
High risk group for HIV of Hep B/C Yes / No
High Blood Pressure Yes / No

- 10. Have you had any other serious illness, if so please state
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- 11. When was your last dental check-up?
- 12. What is the purpose of your visit today?
- 13. Do you have a particular concern (eg sensitive teeth, bleeding
gums)?
- 14. Are you happy with the appearance of your teeth?
- 15. Do you wish to discuss anything privately with the dentist?

Signature Date Dentist
(Patient / Guardian)

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