WINDSOR DENTISTS
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Health History Form

Welcome! It is important to know details about your medical history as these could affect the success of your dental treatment and how we can provide this treatment safely for you. To provide you with the best possible care, please complete **ALL SECTIONS** of **BOTH PAGES** of this form. The information you provide is confidential and will be handled in accordance with our privacy policy which is attached to the clipboard.

Title	Given Name(s)	Surname	Date of Birth:

Address:	Suburb:	State:	Postcode:

Home Phone: ( )	Work Phone: ( )	Mobile:

Email:	Occupation:

Emergency Contact:	Relationship:	Phone: ( )

How did you find us?

☐ Family or friend ☐ Internet or website ☐ Walked by ☐ Flyer or ad ☐ Other _____

	Yes / No	
Do you have a health fund	☐ ☐	Health Fund Name: Health Fund number:

Dental Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes / No
Are you currently experiencing dental pain or discomfort?	☐ ☐
Do your gums bleed when you brush or floss?	☐ ☐
Are your teeth sensitive to cold, hot, sweet or pressure	☐ ☐
Does food or floss catch between your teeth?	☐ ☐
Do you have any of the following:	
Broken teeth or fillings	☐ ☐
Discoloured teeth or fillings	☐ ☐
Loose teeth	☐ ☐
Bad breath	☐ ☐
Dry mouth	☐ ☐
Earaches or neck pains	☐ ☐
Concerns regarding missing teeth	☐ ☐
Concerns regarding crowded teeth	☐ ☐

Have you ever had:	Yes / No
Periodontal (gum) treatments?	☐ ☐
Orthodontic (braces) treatments?	☐ ☐
Serious injury to you head or mouth?	☐ ☐

How long since your last dental visit?

Overall, how do you rate your dental health? (please circle)

1 2 3 4 5

Poor Excellent

What is the reason for your dental visit today?

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes / No		Yes / No
Are you being treated by a doctor at present	☐ ☐	Do you smoke	☐ ☐
Who is your medical practitioner? Phone: ( )		How many a day? _____	
Have you been hospitalised in the last 12 months?	☐ ☐	WOMEN ONLY Are you:	
If yes, what was the illness of problem?		Pregnant	☐ ☐
		Number of weeks: _____	
		Nursing	☐ ☐
Has a doctor or previous dentist recommended that you routinely take antibiotics prior to your dental treatment?			☐ ☐
Are you taking or have you recently taken any prescription or over the counter medicine(s)? If so, please list all:			☐ ☐

Heart or Circulatory Conditions	Yes / No	Lung / Respiratory Conditions	Yes / No	Blood Related Conditions	Yes / No
Stroke / Heart Attack	☐ ☐	Asthma	☐ ☐	Excessive Bleeding	☐ ☐
High Blood Pressure	☐ ☐	Bronchitis, Emphysema Other Lung Disease	☐ ☐	Contact with HIV, Hepatitis B or Hepatitis C	☐ ☐
Low Blood Pressure	☐ ☐	Tuberculosis	☐ ☐	Anaemia, leukaemia or other blood diseases	☐ ☐
Artificial Heart Valve	☐ ☐	Anxiety or panic attacks	☐ ☐		
Pace Maker	☐ ☐				

Other Conditions	Yes / No		Yes / No	Allergies	Yes / No
Diabetes (Type I or Type II)	☐ ☐	Steroid therapy	☐ ☐	Latex	☐ ☐
Cancer (any type)	☐ ☐	Hepatitis, kidney or liver disease	☐ ☐	Penicillin or other antibiotic	☐ ☐
Radiation therapy	☐ ☐	Stomach or digestive condition	☐ ☐	Codeine	☐ ☐
Bone diseases, including osteoporosis	☐ ☐	Thyroid disease	☐ ☐	Other	☐ ☐
		Epilepsy	☐ ☐	Specify: _____	
Joint replacement e.g. hip, knee	☐ ☐	Other neurological condition	☐ ☐		

Do you have any disease, condition, or problem not listed above that you think we should know about?

I understand:

- That my personal and medical information will be treated in the strictest confidence in accordance with the Privacy Act.
- That all treatment is to be paid for on the day of treatment and that no accounts are issued.
- That to keep things fair for all our patients, a fee may apply if a minimum of 24 hours notice is not given for cancellation or no-show for an appointment time.

Your signature:

Date:

If patient is under 18 years old
Name of parent / guardian completing the form:

Relationship to the patient: