



# Medical History Questionnaire

Welcome to Greenwood Dental. In order to provide you with complete quality care we need to know about your state of health and medical history. In accordance with the Privacy Amendment Act 2000, and the Health Records and Information Privacy Act 2002, all information provided will be treated in strictest confidence and available only to third parties you have consented to. Please complete as accurately as possible. **Thank you**

**Patient information**

Title Dr / Mr / Mrs / Miss / Ms \_\_\_\_\_

Surname \_\_\_\_\_ First name \_\_\_\_\_ Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home address \_\_\_\_\_ Postcode \_\_\_\_\_

Postal address \_\_\_\_\_ Postcode \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (M) \_\_\_\_\_

Email \_\_\_\_\_

Occupation \_\_\_\_\_

Employer's name \_\_\_\_\_

Health fund for dental cover \_\_\_\_\_ Membership No. \_\_\_\_\_ Series No. \_\_\_\_\_

Emergency contact \_\_\_\_\_ Relation to patient \_\_\_\_\_ Contact no. \_\_\_\_\_

**Person responsible for account (must be completed if patient under 16, if same as above please tick here )**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

If third party, insurance company/employer responsible for account \_\_\_\_\_

Contact name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Postcode \_\_\_\_\_

**Past/current medical conditions**

Information about your medical history is for your dentists use only. All dental treatment provided at Greenwood Dental is performed by independent dentists.

|                            | No                       | Yes                      |                         | No                       | Yes                      |
|----------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|
| Anaemia                    | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure     | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis                  | <input type="checkbox"/> | <input type="checkbox"/> | Intellectually Disabled | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Joints          | <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heart Beat    | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma                     | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorder         | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding Disorder          | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disorder          | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Transfusion          | <input type="checkbox"/> | <input type="checkbox"/> | Lung Disorder           | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer                     | <input type="checkbox"/> | <input type="checkbox"/> | Lupus                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemotherapy               | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker               | <input type="checkbox"/> | <input type="checkbox"/> |
| Cholesterol                | <input type="checkbox"/> | <input type="checkbox"/> | Physically Disabled     | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes                   | <input type="checkbox"/> | <input type="checkbox"/> | Radiotherapy            | <input type="checkbox"/> | <input type="checkbox"/> |
| Endocarditis               | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever         | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy                   | <input type="checkbox"/> | <input type="checkbox"/> | Smoker                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Gastro Intestinal Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Ulcer           | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack/Angina        | <input type="checkbox"/> | <input type="checkbox"/> | Stroke                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Bypass               | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disorder        | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur               | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis            | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Valve Problem        | <input type="checkbox"/> | <input type="checkbox"/> | Are you Pregnant?       | <input type="checkbox"/> | <input type="checkbox"/> |
| Others                     | <input type="checkbox"/> | <input type="checkbox"/> | Specify _____           |                          |                          |

**Current medication**  
(Prescription, over the counter, herbal)

**Allergies**

Nil known  
 Yes - Details

**Infectious history**

Nil known  
 Yes - Details

**Recent hospitalisation/surgery**

Nil known  
 Yes - Details

**Other relevant details**

Nil known  
 Yes - Details

Medical practitioner \_\_\_\_\_ Suburb \_\_\_\_\_  
Last visit \_\_\_\_\_  
Previous dentist \_\_\_\_\_  
Last dental visit \_\_\_\_\_

I agree that the above is a true and accurate record. I understand that this Greenwood Dental Centre requires payment on the day of treatment. Any expenses, costs or disbursements incurred by the Greenwood Dental Centre in recovering any outstanding monies including debt collection fees and legal costs shall be paid by the responsible party above. I further acknowledge that failure to attend any appointment without notice may also result in a deposit requirement prior to future appointments being scheduled.

**PLEASE NOTE:**

The medical history form will be electronically copied to your clinical record file and the original will be subsequently destroyed. By signing this document you agree to this process. This form is a guide only and you should discuss any relevant matters with your Dentist prior to the commencement of any dental treatments.

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_