TUH CONFIDENTIAL MEDICAL HISTORY FORM

It's important we know your medical history as this could affect the outcome of your dental treatment and how we can provide this treatment safely for you. The information you provide is confidential and will be handled in accordance with our Privacy Policy (available upon request or from www.tuh.com.au)

Name: _____
Surname | First names | Title

Client Number: _____ Date of birth: _____

Emergency contact: _____
Name | Relationship | Phone number

Medical practitioner: _____
Name | Practice address | Phone number (if known)

MEDICAL HISTORY

1 Are you currently receiving any medical treatment? ❒Yes ❒No
Details:

2 Have you been a patient in hospital during the past 12 months? ❒Yes ❒No
Details:

3 Are you taking any medications? ❒Yes ❒No
Details:

4 Have you experienced allergies or unusual effects from any medication or anaesthetic? ❒Yes ❒No
Details:

5 Please tick if you have or ever had any of the following:

- ❒ Allergy to latex
- ❒ Anaemia – type _____
- ❒ Anxiety/nervousness
- ❒ Asthma
- ❒ Arthritis
- ❒ Bronchitis/chest problems/lung disease
- ❒ Cancer/radiation treatment
- ❒ Cold sores
- ❒ Depressive illness
- ❒ Diabetes – type I❒ II❒
- ❒ Epilepsy – date of last seizure / /
- ❒ Hepatitis - type A❒ B❒ C❒
- ❒ Heart condition or disorder
- ❒ High blood pressure/hypertension
- ❒ HIV or risk of HIV exposure
- ❒ Immune suppressed condition
- ❒ Kidney trouble
- ❒ Osteoporosis
- ❒ Rheumatic fever
- ❒ Stroke
- ❒ Thyroid condition
- ❒ Any other conditions _____

6 Women: are you pregnant? ❒Yes ❒No Due date / /
Are you breastfeeding? ❒ Yes ❒No

7 Have you had any prosthetic surgery? (eg. heart valve, knee or hip replacement)? ❒Yes ❒No
Surgery date: / / Specialist:

8 Are you taking bisphosponate medication? ❒Yes ❒No
Type: For how long: Route of delivery:

9 Do you smoke? ❒Yes ❒No
Product smoked (eg. cigarettes, pipe etc): Number per day/week:

DENTAL HISTORY

1 Has your medical practitioner recommended antibiotic cover for dental treatment? ❒Yes ❒No

2 Approximate date of last dental visit (if not TUH): / / ❒Yes ❒No

3 Do you currently have dental pain or a dental problem? ❒Yes ❒No
Details:

4 Do you experience excessive bleeding or bruising from dental treatment, cuts or scratches? ❒Yes ❒No

Please advise us of any other aspect of your medical history (eg. hearing impairment, autism spectrum, ADHD, etc....)
Details:

Signed: Patient/Parent/Guardian _____ Date: _____