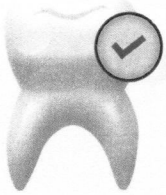

Warracknabeal Dental Clinic

prompt gentle care

Patient Health Summary

First Name _____ **Last Name** _____ **Date of Birth** / /

Medical History

To the best of your knowledge do you have or have you suffered from the following?
If possible please provide approximate date of diagnosis.

- ☐ High Blood Pressure _____
- ☐ Stroke _____
- ☐ High Cholesterol _____
- ☐ Arthritis _____
- ☐ Respiratory/Lung disease _____
- ☐ Cardiac/Heart Disease _____
- ☐ Anxiety _____
- ☐ Broken Bones _____
- ☐ Bowel problems _____
- ☐ Ulcer _____
- ☐ Digestive problems _____
- ☐ Mental Health/Psychology _____
- ☐ Gynaecology/Women's problems _____
- ☐ Heart Disease _____
- ☐ Diabetes _____
- ☐ Cancer If so, where _____
- ☐ Asthma _____
- ☐ Urinary/Kidney problems _____
- ☐ Neurological(nerves)problem _____
- ☐ Sleep disturbance/apnoea _____
- ☐ Osteoporosis _____
- ☐ Immunity problems _____
- ☐ Paget's Disease _____
- ☐ Back or neck problems _____
- ☐ Infectious Disease e.g. MRSA/VRE/STD/HIV _____

Do you think you may be pregnant? If so, how many weeks? _____

Have you ever had surgery? Please state the type of surgery and approximate year.

_____

_____

Do you/have you received physiotherapy, chiropractic or osteopathic treatment for jaw related problems?

_____

Do you smoke? Yes ☐ No ☐ If Yes how many per day? _____

Do you drink alcohol? ☐ Daily ☐ Weekly ☐ Monthly Approximate number of drinks? _____

Any other medical history your Dentist should be made aware of? _____

Allergies and Adverse Reactions

Do you have any allergies? Yes ☐ No ☐ If Yes please state allergy and its affect upon you.

_____

Medicines

There are many medications that may impact upon your oral health or the treatment we plan for you. Please indicate medications that you are currently taking or have taken most recently.

- ☐ Antibiotics _____
- ☐ Heart or Blood Pressure medication _____
- ☐ Hormone Replacement Therapy _____
- ☐ Diabetes medication _____
- ☐ The contraceptive pill (may affect blood pressure or blood clotting & interacts with antibiotics) _____
- ☐ Cancer Medication or Therapy _____
- ☐ Arthritis medications or creams _____
- ☐ Anti-inflammatories e.g. Nurofen, Ibubrofen, Voltaren, Aclin _____
- ☐ Asthma medications or inhalers _____
- ☐ Diet medications/ drinks or tablets _____
- ☐ Pain killers e.g. aspirin, panadol, codeine _____
- ☐ Bisphosphonates e.g. Didronel, Bonefos, Fosomax, Alendro, Actonel, Skelid, Aredia, Pamisol, Zometa

_____

- ☐ Natural therapies _____
- ☐ Nicotine Replacement Therapy _____
- ☐ Other Medications, please list

_____

Immunisations

Please indicate all immunisations that you have received

_____

Patient Signature _____ **Date** _____