Gorokan Dental Centre - Medical History

99 Wallarah Rd, Gorokan NSW 2263

Miss/Ms/Mrs/Mr/Dr SURNAME _____ FIRST NAME _____

Date of birth / /

Address_____ _____ Post Code_____

Phone: Home_____ Mobile_____

Employer_____ Email _____

Old age pension number (If applicable) _____ Health Fund eg MBF _____

Medical Doctor's Name_____ Suburb _____

Please answer each of the following by **circling YES or NO** or listing where required.
Have you had / or are suffering from:
Are you **allergic** to any foods/plants/latex or any antibiotics /medications**: NO / YES** - please list
1 _____ 2 _____ 3 _____

Joint replacement therapy?	No	Yes	If Yes, when? _____
Radiation therapy to head or neck?	No	Yes	If Yes, when? _____
Hepatitis A, B or C?	No	Yes	If Yes, A, B or C? _____
Are you taking any medication?	No	Yes	**If yes, please list:** _____
Cancer Therapy/Osteoporosis/Paget's disease	No	Yes	_____
Rheumatic Fever?	No	Yes	_____
Heart Murmur?	No	Yes	_____
Endocarditis?	No	Yes	_____
Artificial Heart Valve?	No	Yes	
High Blood Pressure?	No	Yes	
Diabetes?	No	Yes	
Asthma?	No	Yes	
Cardiac Pacemaker?	No	Yes	
HIV / AIDS	No	Yes	
Tuberculosis?	No	Yes	
Cardiomyopathy?	No	Yes	
Creutzfeldt-Jacob Disease (CJD)?	No	Yes	
Epilepsy?	No	Yes	
Do you smoke?	No	Yes - Average per day_____	
Any other serious illness?	No	Yes - Please list: _____	
If female, are you pregnant?	No	Yes - (due_____	

Name:

PLEASE NOTE ALL ACCOUNTS ARE TO PAID FOR ON COMPLETION OF APPOINTMENT

Signature _____ Date: