Highlands Family Dental
Dr. Ron Georgiou & Associates
DENTAL SURGEONS

# Medical History Form

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Surname: _____ Given Names: _____ Date of Birth: _____

Address: _____

Email: _____ Phone _____

Parent/Guardian if under 18: _____

***To assist in your treatment and to safeguard yourself and others, we ask you to answer the following, which is in strict confidence. After completing, close and hand to the Dentist.***

1. Do you feel very nervous about having dental treatment? ☐ Yes ☐ No
2. Have you been hospitalised in the past two years? ☐ Yes ☐ No
3. Have you been under care of a doctor in the last two years? ☐ Yes ☐ No
4. Do you smoke or have you previously been a smoker? ☐ Yes ☐ No
5. Are you allergic to penicillin, aspirin or any other medications? Please list below. ☐ Yes ☐ No

6. Have you ever had excessive bleeding? ☐ Yes ☐ No
7. Are you in any of the following high risk groups? (You do not have to state which group) ☐ Yes ☐ No
   - ☐ Have you had blood transfusions or blood product – Antibodies to the HIV virus (AIDS)
   - ☐ Users of drug of addiction either taken orally or by injection – Occupations involving sexual activity.

   This information enables us to take the relevant measures to prevent infection transmission
8. Tick any of the following which you have had or have at present: ☐ Yes ☐ No

| | | |
|---|---|---|
| ☐ Heart Disease or Attack | ☐ Emphysema | ☐ Angina |
| ☐ Tuberculosis (TB) | ☐ High Blood pressure | ☐ Asthma |
| ☐ Heart Murmur | ☐ Allergies or Hives | ☐ Rheumatic Fever |
| ☐ Diabetes | ☐ Congenital Heart Lesions | ☐ Thyroid Disease |
| ☐ Artificial Heart Valve | ☐ X-ray or Cobalt Treatment | ☐ Heart Pacemaker |
| ☐ Artificial Joint | ☐ Heart Surgery | ☐ Cortisone medication |
| ☐ HIV Virus (AIDS) | ☐ Glaucoma | ☐ Anaemia |
| ☐ Yellow Jaundice | ☐ Stroke | ☐ Hepatitis A or B or C |
| ☐ Epilepsy or Seizures | ☐ Liver Disease | ☐ Ulcers |
| ☐ Venereal Disease | ☐ Haemophilia | ☐ Blood Transfusion |
| ☐ Chemotherapy (Cancer, Leukaemia) | ☐ Drug Addiction | ☐ Sickle Cell Disease |

9. When you walk up stairs or take a walk, do you ever have to stop because of pain in the chest, or shortness of breath,or because you are very tired? ☐ Yes ☐ No
10. Do your ankles swell? ☐ Yes ☐ No
11. Do you use more than two pillows to sleep? ☐ Yes ☐ No
12. Do you have any disease, condition or problem not listed? Please list below. ☐ Yes ☐ No

13. Are you presently taking or have you taken in the past any blood thinning medication (eg. Fosamax, Actonel, Prolia, Alendronate, Denosumab, Aclasta, Boniva)? ☐ Yes ☐ No
14. Are you presently taking or have you taken in the past any blood thinning medication? ☐ Yes ☐ No
15. Are you presently taking any medication? Please list below. ☐ Yes ☐ No

16. WOMEN: Are you pregnant now? ☐ Yes ☐ No
17. Do you belong to a Health Fund for Dental Treatment? Please provide details ☐ Yes ☐ No

    Membership Number: ID Number:

***To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.***

Date: _____ Signature _____ *(if under 18 parent or guardian)*

**CONFIDENTIAL INFORMATION**