PROACTIVEPERIO
Periodontics & Implant Dentistry

MEDICAL/DENTAL HISTORY FORM

When it comes to your dental health, are you proactive or reactive? (circle) **PROACTIVE / REACTIVE**

Title: (circle) Dr / Mr / Mrs / Miss / Ms

Full Name: _____

Preferred Name: _____ Date of Birth: ____/____/_____Occupation: _____

Home Phone: _____ Mobile Phone: _____

Home Address: _____

Suburb: _____ State: _____ Postcode: _____

E-mail address: _____

Emergency Contact Name: _____ Phone: _____

General Practitioner: _____ Practice Name: _____

Do you have Private Health Insurance with dental extras cover? YES / NO

Fund Name: _____

Card number: _____ Reference number: _____

Medicare Number: _____ Patient # on Card: _____ Valid to: _____

DVA number: _____ Card Type: _____

How did you hear about us? (please circle): Dentist Referral / Internet Search / Friend or Family / Other

What is the name of your general dentist and their practice? _____

PLEASE CIRCLE AND PROVIDE DETAILS:

Are you receiving any medical treatment at present? YES / NO

Details: _____

Are you currently seeing a medical or other dental specialist for any reason? YES / NO

Details: _____

Have you been in hospital or had surgery during the past two years? YES / NO

Details: _____

Please list **all** your medications on the Medical Record Form, including painkillers, aspirin and any supplements

Do you have any allergies including latex, medication, tablets or antibiotics? YES / NO

Details: _____

Have you had any prosthetic surgery (e.g. Heart valve, stent, joint replacement)? YES / NO

Details: _____

What is your smoking status? (please circle) SMOKER / EX-SMOKER / NON-SMOKER

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How many years did you smoke/have you smoked? _____ Cigarettes per day: _____

Are you currently receiving, or have you ever received, treatment for cancer? YES / NO

If Yes, Please specify: _____

Are you currently pregnant or breastfeeding? YES / NO

How many standard drinks of alcohol do you consume per week? _____

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING CONDITIONS?

Heart condition	YES / NO	High blood pressure	YES / NO	Low blood pressure	YES / NO
Steroid therapy	YES / NO	Kidney disease	YES / NO	Prosthetic implant	YES / NO
Rheumatic fever	YES / NO	Excessive bleeding	YES / NO	Cardiac pacemaker	YES / NO
Epilepsy	YES / NO	Stroke	YES / NO	Digestive condition	YES / NO
Asthma	YES / NO	Cancer	YES / NO	Liver Conditions	YES / NO
Diabetes	YES / NO	Tuberculosis	YES / NO	Blood borne virus	YES / NO
Thyroid disease	YES / NO	Lung condition	YES / NO	Bone disease	YES / NO
Depression/Anxiety	YES / NO	Blood disease	YES / NO	Radio/Chemo therapy	YES / NO
Sinus trouble	YES / NO	Bisphosphonate meds	YES / NO	Arthritis	YES / NO
Hep A/B/C	YES / NO	HIV / AIDS	YES / NO	Do you take aspirin?	YES / NO

Do you have any other medical conditions not listed here? _____

Do you have any family history of Diabetes or cardiovascular/ Heart issues? _____

Do you take any blood-thinners (e.g. Aspirin, Plavix, Warfarin etc.) or bone agents (e.g. Fosamax, actinol, prolea etc.)? Please list **all** your medications on the Medical Record Form.

DENTAL HISTORY

1. When was your last dental examination carried out? _____
2. Have you previously been diagnosed with or treated for gum disease? _____
3. Are you currently experiencing pain, sensitivity or soreness in your mouth?

   Details: _____
4. Do dental visits make you feel anxious or nervous? _____
5. Are you satisfied with the function and/or appearance of your teeth? _____

I, _____ acknowledge that the information given on this form is accurate and true. I understand that full payment of my account on the day of my appointment is my responsibility. I will notify my clinician of any change in my health or medication. Should further information be required regarding my medical status, I give permission for my healthcare provider/s to release said information to Proactive Perio.

Signature: _____ Date: _____/_____/_____