PATIENT HEALTH SUMMARY

Updated:____ /____/_____

Sign:_____

My Body DENTAL
www.mybodydental.com

PERSONAL DETAILS

Title:_____ Surname: _____ Given names: _____ DOB:_____

Residential Address:_____PC_____

Postal Address:_____PC_____

Phone: Hm _____ Wk _____ Mb _____ Email: _____

Occupation:_____Employer: _____Drivers licence: _____Exp____

Health Fund and Member no: _____

GP Name:_____GP Phone:_____

In case of an emergency please contact: Name: _____ Phone:_____

How did you hear about/who referred you to My Body DENTAL? :_____

MEDICAL HISTORY

To the best of your knowledge do you have or have you suffered from any of the following? (please provide approximate date of diagnosis):

Please Tick:

- ☐ High Blood Pressure_____
- ☐ High Cholesterol_____
- ☐ Stroke_____
- ☐ Vascular Disorder_____
- ☐ Heart / Cardiac Disease / Heart Operations_____
- ☐ Heart Murmur / Heart Valve Replacements / Pacemaker
- ☐ Rheumatic Fever_____
- ☐ Internal Prosthetics (artificial hip, knee, heart valve, pacemaker, shunts, stents, pins, plates etc)_____
- ☐ Diabetes (IDDM or NIDDM)_____
- ☐ Asthma_____
- ☐ Respiratory / Lung Disease (bronchitis, emphysema, breathing problems, COAD etc)_____
- ☐ Liver problems_____
- ☐ Kidney (urinary) problems_____
- ☐ Bowel problems_____
- ☐ Stomach / Digestive problems (ulcer, reflux)_____
- ☐ Thyroid Problems_____
- ☐ Hormonal Problems_____
- ☐ Blood Disorders / Bleeding Problems (anaemia, haemophilia, Factor V deficiency, thalassemia)_____
- ☐ Cancer _____
- ☐ Radiotherapy / Chemotherapy date:_____
- ☐ Immunity Problems_____
- ☐ Broken Bones_____
- ☐ Bone Disorders (Osteoporosis, Paget's disease)_____
- ☐ Arthritis_____
- ☐ Epilepsy / Fits_____
- ☐ Infectious Diseases (HIV, Hepatitis, STD's, Tuberculosis, MRSA,VRE)
- ☐ Neurological (nerves) problems_____
- ☐ Mental Health / Psychological (anxiety, depression)_____
- ☐ Back or neck problems_____
- ☐ Sleep Apnoea / sleep disturbances_____
- ☐ Gynaecological / Women's problems_____
- ☐ Other medical problems or disabilities_____

Please circle Y / N:

Have you been hospitalised or seriously ill in the last 12 months? **Y / N** If yes, details:_____

Have you ever stayed in hospital, had a general anaesthetic and/or surgery? **Y / N** If yes, please state type of surgery and year:_____

Have you ever had a reaction to Local or General Anaesthetic? **Y / N** If yes, details:_____

Have you ever undergone neurosurgery (prior to 1982) or growth hormone treatment (prior to 1985) or do you (or any members of your family) have a history of Creutzfeld-Jacob Disease (CJD)? **Y / N** If yes, details:_____

Do you have, or have you ever had, physiotherapy, chiropractic or osteopathic treatment for jaw related problems? **Y / N**

Are you pregnant? **Y / N** If yes, how many weeks? _____

Do you smoke? **Y / N** If yes, how many per day? _____

Do you drink alcohol daily/weekly/monthly? _____

Are you using recreational drugs orally or IV? **Y / N** If yes, details:_____

Have dental problems ever made you sick or have you ever had problems with dental treatment? **Y / N** If yes, details:_____

Do you have any other relevant medical problems your Dentist should be made aware of? **Y / N** If yes, details:_____

ALLERGIES & ADVERSE REACTIONS:

Do you have any allergies (penicillin, latex, other medications, foods)? **Y / N** If yes, details (please list their effects on you):_____

_____

_____

MEDICATIONS (there are many medications that may impact upon your oral health or the treatment we plan for you so please indicate any medications that you are currently taking or have taken recently): Please Tick

- ☐ Antibiotics_____
- ☐ Heart or Blood Pressure Medication_____
- ☐ Hormone Replacement Therapy_____
- ☐ Diabetes Medication _____
- ☐ Contraceptive Pill (may affect blood pressure or blood clotting & interacts with antibiotics)_____
- ☐ Cancer Medication or Therapy_____
- ☐ Arthritis medications or creams_____
- ☐ Anti-inflammatories (nurofen, ibuprofen, voltaren)_____
- ☐ Asthma medications or inhalers_____
- ☐ Diet medications/drinks or tablets_____
- ☐ Pain killers (aspirin, panadol, codeine) _____
- ☐ Bisphosphonates (Didronel, Bonefos, Fosamax, Alendro, Actonel, Skelid, Aredia, Pamisol, Zometa)_____
- ☐ Blood thinners (warfarin, heparin, aspirin, clopidogrel)_____
- ☐ Natural therapies _____
- ☐ Nicotine Replacement Therapy_____
- ☐ Other medications (please list):_____

If you have any questions regarding any of the above information please do not hesitate to talk to one of our staff members or your treating dentist. I hereby declare that the information I have provided is true and correct to the best of my knowledge.

Signature of Patient/Parent or Guardian _____ Date_____

(if patient is a minor)