Aqua Dental Care - Patient Medical History

Title	☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Master
First Name	
Last Name	
Preferred Names	
Date Of Birth	/ /
Gender	☐ Male ☐ Female
Occupation	
Parent / Guardian	

Home Phone	( )	Mobile Phone	
Email			
Method of contact	☐ Telephone ☐ SMS ☐ Email		

Street Address			
Suburb			
Postcode		State	

Emergency Contact	
Emergency Phone	

Health Fund And/or Medicare Details

Health Fund			
Membership No.			
Expiry Date	/ / 20	No. on Card	
Medicare Number			
Reference on Card			

Medical History (if you answer Yes, Place Provide the details)

Have You Ever Been Hospitalised ?	☐ No ☐ Yes	If Yes, When ?
Have you had A Joint replacement Surgery ?	☐ No ☐ Yes	
Do You Smoke ?	☐ No ☐ Yes	
Are you Taking Any Medications ? If yes,Please list.	☐ No ☐ Yes	
have you got any other Important health Issues ?	☐ No ☐ Yes	
Are you under care of doctor?	☐ No ☐ Yes	
Doctor's Name		
Location		Telephone

For Females ***(if you answer YES, place provide the details)***

Are You Pregnant	☐ No ☐ Yes	
Are you on Contraceptive medicine	☐ No ☐ Yes	

Have you suffered one of the following

Epilepsy	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes
Rheumatic Fever	☐ No ☐ Yes	Asthma	☐ No ☐ Yes
High/Low Blood Pressure	☐ No ☐ Yes	Haemophilia / Prolonged Bleeding	☐ No ☐ Yes
Heart Conditions	☐ No ☐ Yes	HIV/AIDS	☐ No ☐ Yes
Blood Disease	☐ No ☐ Yes	Hepatitis	☐ No ☐ Yes

General Allergies

Hayfever	☐ No ☐ Yes	Latex	☐ No ☐ Yes
Food Allergies	☐ No ☐ Yes	Nickel	☐ No ☐ Yes
Insect Stings	☐ No ☐ Yes	Amalgam	☐ No ☐ Yes
Animal Allergies	☐ No ☐ Yes	Chromium	☐ No ☐ Yes

Allergies TO Drugs

Penicillins	☐ No ☐ Yes	Meprobamate	☐ No ☐ Yes
Codeine	☐ No ☐ Yes	Thiazide Diuretics	☐ No ☐ Yes
lodines	☐ No ☐ Yes	insulin	☐ No ☐ Yes
Salicylates	☐ No ☐ Yes	Opiates	☐ No ☐ Yes
Heparin	☐ No ☐ Yes	Sulfonamides	☐ No ☐ Yes
Barbiturates	☐ No ☐ Yes	Procaine / Novocaine	☐ No ☐ Yes
Tetracaine	☐ No ☐ Yes	Propoxicane	☐ No ☐ Yes
Benzocaine	☐ No ☐ Yes	Procainamide	☐ No ☐ Yes
Are you allergic to other unlisted drugs ?	☐ No ☐ Yes		

I declare that:

- I have completed this questionnaire to the best of my knowledge and ability, and understand that failure to make a full disclosure may place me and the staff at an undue medical risk.

-I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as Indicated and I will assume responsibility for the fees associated with these procedures. I am aware that payment is required on the day of treatment.

-l understand the practice requires at least 24 hours' notice If I need to cancel or reschedule my appointment

Patient/Guardian Signature: ..... Date: .....