Confidential Medical History

Heasley DENTAL

Personal Details		
Name	Preferred name	
D.O.B.	Gender Male	Title Mr

Address Details		
Address	Suburb	Post Code
Contact Number	Email Address	
Emergency Contact Name	Emergency Phone	
Health Fund Name	Doctor's Name	
Medicare # (U18 only)	Position on card	

Medical History

Please list any medication being taken:

Are you having treatment for cancer? No Type of Treatment:

Are you taking any Bisphosphonate medications? No ☐ Tablet ☐ Injection

Commonly prescribed Bisphosphonates are: Nitrogen-containing Bisphosphonates
Osteoporosis - **Fosamax** (Alendronate) **Actonel** (Risedronate) Cancer Therapy - **Pamidronate, Aredia** (Disodium Pamidronate) **Zometa, Zoledronate** (Zoledronic acid)
Non-nitrogen- containing Bisphosphonates: Osteoporosis - (Etidronate) Cancer Therapy - **Bonefos, Loron** (Sodium Clodronate) Paget's Disease - **Skelid** (tiludronate)

Has your doctor recommended an antibiotic cover for dental treatment? No

Do You Have Any Of The Following **(tick all that apply)**

☐ Osteoporosis	☐ Epilepsy	☐ Diabetes	☐ Low blood pressure
☐ Heart condition	☐ Asthma	☐ Rheumatic Fever	☐ Blood Disease
☐ Kidney Disease	☐ High blood pressure	☐ Hepatitis A/B	☐ Any joint replacements
☐ Prolonged bleeding	☐ Do you smoke?	☐ Emphysema	☐ HIV/AIDS
☐ Difficulty Breathing	☐ Stroke/TIA	☐ Neurological Issues	☐ Hearing Difficulty
☐ Arthritis	☐ Pacemaker	☐ Reaction to anaesthetic	☐ Do you carry an EpiPen
☐ Thyroid	☐ Are you pregnant?	If pregnant #weeks _____	

Any ALLERGIES to the following **(tick all that apply)**

☐ Aspirin	☐ Codeine	☐ Latex	☐ Penicillin	☐ Metals
☐ Erythromycin	☐ Sulphur	☐ Tetracycline	☐ Peanuts	☐ Dental Anaesthetics

Other Allergies: _____

Please list any further information/important health issues

I understand that the above information is accurate and complete to the best of my knowledge. I understand that providing incorrect information could be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Name		Signature		Date	

Person Signing ☐ Patient ☐ Parent ☐ Guardian

How did you hear about our practice? ☐ Website ☐ Social Media ☐ Friends ☐ Google ☐ Other

ADMIN USE ONLY ☐ Entered into system ☐ Scanned Completed by: _____ Date: _____