The Health Hub Confidential Medical History

Name: ……..

Date of Birth: ……..

Emergency Contact: ..... Ph:.....

Medical Doctor: ..... Ph: .....

Confidential Medical History

Please confirm details as relevant and leave other fields blank

Warnings			
Hearing/ Sight Impairment		Do Not Recline	
Antibiotic Cover required		Steroids within 2 years	
Bruising or persistent bleeding		Warning Card	
Currently under treatment		Treatment requiring hospital	
Details			

Medications

Heart			
Rheumatic Fever		Heart Murmur	
High or Low Blood Pressure		Angina	
Heart Surgery		Thrombosis	
Pacemaker fitted		Other Heart Conditions	
Details			

Blood			
Hepatitis A,B,C or D		Anaemia	
H.I.V/ AIDS		Sickle Cell	
Abnormal Blood Test		Haemophilia	
Blood refused by transfusion svce		Other Blood Conditions	
Details			

Allergies			
Penicillin		Latex Allergy	
Hay Fever		Medicines	
Anti-Tetanus Serum		Plants	
Eczema		Foods	
General Anaesthetic		Aspirin	
Local Anaesthetic		Other Allergy Conditions	
Details			

Chest			
Bronchitis		Emphysema	
Cystic Fibrosis		Pneumonia	
Pleurisy		Chest Surgery	
Asthmatic		Other Chest Conditions	
Details			
Other Conditions			
Liver Disease		Kidney Disease	
Diabetes		Epilepsy	
Acid Reflux or Eating Disorder		Hiatus Hernia	
Bone or Joint Disease		Artificial Joint	
Fainting Attack or Blackouts		Giddiness	
Past serious or infectious disease		Cancer/ Radiotherapy	
Depressive Illness		Stroke	
Nervous Problems		Tuberculosis	
Severe Headaches		Cold Sores	
Lifestyle			
Smokes (per day)		High sugar	
Chew tobacco (per day)		Lots of fizzy/acidic drinks	
Alcohol (units per week)		Recreational drugs	
Pregnancy or possibly pregnant		Please add anything dentist should know	
If you are pregnant … please confirm how many weeks.			
Details			

I have completed this Questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue medical risk. I understand that notes, radiographs (x-rays) or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this.

Signed by: Guardian/Patient: ..... Date: .....

Name: .....

ON FUTURE VISITS ANY CHANGES TO THE ABOVE SHOULD BE ADVISED.
AT ANY STAGE IF YOU HAVE CHANGED HEALTHFUNDS OR ARE PLANNING TO CLAIM THROUGH WORKCOVER OR MEDICARE CHILD DENTAL SCHEME, PLEASE LET ONE OF OUR FRIENDLY STAFF MEMBERS KNOW.
THANK YOU.