East Rand DentalStudio

NEW PATIENT
Medical History Form

Welcome to East Rand Dental Studio

Please answer these questions as completely as possible. It will assist us greatly in our effort to provide the best dental treatment for you.

Patient details

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ID number: | | | | | | | | | | | | | |

Surname: _____ Full name: _____

Medical history

- ☐ Angina
- ☐ Artificial heart valve
- ☐ Blood pressure
  - ○ Low ○ High
- ☐ Cardiac surgery/pacemaker
- ☐ Congenital heart defect
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Stroke
- ☐ Blood thinner medication
- ☐ Bleeding disorder
- ☐ Rheumatic fever
- ☐ Osteoporosis
- ☐ COPD
- ☐ Asthma
- ☐ Thyroid disorder
  - ○ Under active ○ Over-active
- ☐ Reflux
- ☐ Immune deficiency
- ☐ Rheumatoid Arthritis
- ☐ Kidney/liver disease
- ☐ Artificial joint
- ☐ Diabetes
  - ○ 1 ○ 2
- ☐ Hepatitis
  - ○ A ○ B ○ C ○ D
- ☐ HIV positive
- ☐ Cancer Type: _____
- ☐ Radiation/chemotherapy
- ☐ Neurological disorder
- ☐ Psychiatric care
- ☐ MS
- ☐ Epilepsy
- ☐ Steroid therapy
- ☐ Depression
- ☐ Anxiety

Are you currently taking MEDICATION (inc. natural supplements)? If yes, please list:

_____

Please tick: ☐ Smoker ☐ Non-smoker ☐ Ex-smoker

Are you pregnant? ☐ Yes ☐ No If yes, due date: _____

Were you taking any MEDICATION before getting pregnant? If yes, please list:

_____

Allergies/intolerances

☐ Yes ☐ None

○ Aspirin ○ Iodine ○ Latex ○ Penicillin ○ Sulfa drugs

○ Other (please specify): _____

Dental history

Last dental visit: _____

Have you ever had a reaction or complication following dental treatment in the past? ☐ Yes ☐ No

If yes, please detail: _____

Do you have any private or confidential information you wish to discuss in private and not write down?

☐ Yes ☐ No

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Are you suffering from any of the following?

- ☐ Bad appearance of teeth
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Difficulty chewing
- ☐ Discoloured teeth
- ☐ Dry mouth
- ☐ Grinding/clenching teeth
- ☐ Missing teeth
- ☐ Loose teeth
- ☐ Lost filling/cavity
- ☐ Rapidly decaying teeth
- ☐ Pain in face/jaw
- ☐ Sensitive teeth
- ☐ Sounds from jaw joint
- ☐ Snoring
- ☐ Sleeping problems
- ☐ Unsatisfactory denture
- ☐ Worn or broken teeth

Have you ever had a sleep study and been diagnosed with sleep apnoea? ☐ Yes ☐ No

If yes, have you ever tried Continuous Positive Airway Pressure (CPAP) therapy? ☐ Yes ☐ No

Has anyone ever told you that you snore? ☐ Yes ☐ No

After 6-7 hours of sleep do you wake up refreshed? ☐ Yes ☐ No

How did you find out about us?

☐ Google/web ☐ Facebook ☐ Drive by the location

☐ Family Friend ☐ GP/Dentist – Name: _____

☐ Other (please specify): _____

Anything else you would like to tell us: _____

_____

Signature

By signing this document you acknowledge that you answered all the questions correctly and truthful.

Patient name: _____

Signature: _____ Date: _____

(Parent/Guardian to sign if patient is a minor)