Dr Gwendolin Flanagan BDS
Dentist

Suite 1, 301 Brunker Road, Adamstown
Ph. 02 4956 1515 Fax. 024953 9538
www.gwendent.com.au
ABN 24 942 404 100 Dr Gwendolin Flanagan Family Trust

MEDICAL HISTORY FORM

Your Personal Details

Title:	D.O.B
First Name:	Surname:
Postal Address:	
Suburb:	Postcode:
Mobile No.:	Home No:
Work No.: -	Email Address:
Occupation or place of work:	
Name of Health Fund:	Family Member ID:
Medicare Number:	Medicare Family Member ID:

Best contact phone number for Appointments: (please circle) Mobile Home Work

How did you hear about us?	Patient referral (who):
	Other Dentist (who):
	Other (how):
Emergency Contact - Person to contact:	
Relationship to you:	Contact Number:

Medical Details:

Your Dental History Put in approximate times if you are not exactly sure

When was your last dental treatment?

Last dental cleaning?	Last full mouth x-ray?
Do you feel nervous about your dental treatment?	

Your Medical History Generally (please circle **Yes** or **No** as appropriate)

Are you currently undergoing **any medical treatment**?	Yes	No
Physician's / Surgery Name:		
Physician / Surgery phone number:		
Are you taking any **medication, drugs or pills**?	Yes	No
If yes, name of medication and dosage:		
Are you taking any **Bisphosphonate medication**?	Yes	No
E.g. Aledronate, Risedronate, Disodium Pamidronate, Other- please specify		
Do you have any **allergies**? E.g. Penicillin, Aspirin, Erythromycin, other?	Yes	No
Please specify -		
Are you **Pregnant or Nursing**?	Yes	No

Patient / Guardian Signature:	**Date**:

Please continue over the page

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MEDICAL HISTORY FORM continued

Title: **DOB**:

Please indicate if you have had , or have at present, any of the following –
(please circle Yes or No as appropriate)

Heart Problems	Chest Pain	Yes	No
	Congenital Heart Disease	Yes	No
	Mitral Valve Prolapse	Yes	No
	Heart Murmur	Yes	No
	Artificial Heart Valve	Yes	No
	Heart Pacemaker	Yes	No
	Heart - Surgery, Disease, Attack	Yes	No
	High Blood Pressure	Yes	No
Blood Conditions	Haemophilia	Yes	No
	Hepatitis A B C	Yes	No
	HIV / AIDS	Yes	No
Brain Conditions	Stroke	Yes	No
	Fainting / Dizzy Spells	Yes	No
	Epilepsy	Yes	No
Lung Conditions	Sinus Troubles	Yes	No
	Smoker	Yes	No
	Tuberculosis	Yes	No
	Emphysema / Chronic Cough	Yes	No
	Asthma	Yes	No
	Hay Fever	Yes	No
Bone and Joint Conditions	Artificial Joints (Hip, Knee)	Yes	No
	Other Prosthesis	Yes	No
	Bone disease - specify	Yes	No
	Osteoporosis, Pagets disease, Cancer spread to bone, Multiple Myeloma	Yes	No
Other	Diabetes	Yes	No
	CJD - Creutzfeldt-Jakob disease	Yes	No
	Thyroid Problems	Yes	No
	Stomach Ulcers	Yes	No
	Radiation / Chemotherapy	Yes	No
	Arthritis / Rheumatism	Yes	No
	Rheumatic Fever	Yes	No
	Latex Allergy	Yes	No
	Diet (Special / Restricted)	Yes	No

Patient / Guardian Signature: **Date**: