## Legana Dental Medical History Form

Full Name (Mr/Master/Mrs/Miss/Ms/Dr/O	ther):				
Postal Address (including suburb & postcoo	de):				
Home Phone:	Work Phone:		Mobile:		
Preferred daytime contact: Home / Wo	rk / Mobile <i>(pleas</i>	se circle	<i>e)</i> Date of Birth:		
Email Address:			Occupation:		
			Ooctor's Surgery:		
Do you have Private Dental Insurance?	□ YES □ NO	O If y	es, please specify fund name		
Emergency contact (NAME, RELATIONSHIP	& PH NUMBER):				
How did you hear about us?					
I have private and confidential medical mat	tters which I wish	to disc	cuss with the dentist? $\Box$ $f Y$ $\Box$ $f N$		
Are you of Aberiginal or Torres Strait Island	lor origin2 ¬V (	N			
Are you of Aboriginal or Torres Strait Island	ierongine ut i	⊔ IN			
Please indicate YES or NO if you have $\underline{\text{ever}}$	had any of the fo	llowing	3:		
	Y	N		Υ	N
ADHD / Autism			HIV/AIDS		
Anxiety			Jaw, neck or shoulder injury or pain		
Asthma/Bronchitis/lung conditions			Joint replacement surgery (please specify if yes)		
Blood disorders			Kidney/renal disease	-	1
Chemotherapy/radiation therapy			Osteoporosis or low bone density		
Area  Depression			Nervous system disorder		
Depression			E.g. MS, Alzheimer's or Parkinson's		
Diabetes or family history of diabetes			Rheumatic Fever		
Epilepsy/Seizures			Rheumatoid arthritis/Lupus/Polymyalgia		
Excessive bruising or bleeding			Snoring/Sleep Apnoea		
Gastroesophageal reflux disease			Thyroid Disease		
Heart Condition/Cardiac Surgery/Pacema	aker		Transplanted organ/bone marrow/stem cells		
Heart valve replacement			Treatment for cancer (type/region)		
Hepatitis B/C or liver disease			Tuberculosis (TB)		
High or low blood pressure					
Do you currently smoke? $\Box$ Y $\Box$ N If yes	, how many per d	lay?			
Do you currently use illicit substances and/	or reactional drug	gs? □'	Y D N		
For Women: Are you currently pregnant?	□ Y □ N If yes	, how i	many weeks		
Are you on any of the following medication	ıs? (Please tick th	ose th	at apply)		
□ Cortisone (Prednisolone) □ Diab	etes (Diabex)		☐ Osteoporosis (Fosamax/Actonel/Prolia)		
☐ Blood thinning (Aspirin/Warfarin/Plavix/)	Karelto/Clopidogre	el/Dab	igatran/Rivaroxaban/Apixaban)		<u>P.T.O</u>

Drug Name		Dose Taken	Duratio	n of Use	Purpose/Notes
		<u> </u>			
Allergies/Adv	erse Drug Reaction – e	especially antibiotics (e.g. Po	enicillin), medicines, an	itiseptics, latex, l	ocal anaesthetics etc
Drug Name		Nature of reacti	on	When i	reaction occurred
Would you like	to receive your appoi	ntment reminders via SN (Note: if you tick "N			□ <b>NO</b> your preferred contact method).
		(Note: if you tick "N up reminder, please indic / □ Ema	O" you will receive a reminate below preferred of SMS	nder phone call to	your preferred contact method).
lf you would lik	ke to receive a check-u	(Note: if you tick "N up reminder, please indic / □ Ema	O" you will receive a reminate below preferred i	nder phone call to	your preferred contact method).
If you would lik □ 6 months	xe to receive a check-u □ 12 months	(Note: if you tick "N up reminder, please indic / □ Ema	O" you will receive a reminate below preferred in SMS	nder phone call to	your preferred contact method).
If you would lik □ 6 months Please read the	te to receive a check-u □ 12 months e following statement	(Note: if you tick "Note: if you tick "Note: Please indication")    Ema	O" you will receive a reminate below preferred in SMS lease leave blank if you wis	method.	your preferred contact method).
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