Queensland Government
Queensland Health

ORAL HEALTH SERVICES

It is important to know details about your medical history as these could affect the success of oral health care (dental treatment). The information you provide is confidential.

Last name:	Title *(eg Mr/Mrs/Ms)*: Date of birth: /
First name(s):	Gender Male ☐ Female ☐
Home address: Postal address (if different):	Phone Home: Work: Emergency details Contact: Phone:
I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this *(please tick box)* ☐	

Are you of Aboriginal or Torres Strait Islander or South Sea Islander origin? (please tick ONE box)

No ☐ Aboriginal ☐ Torres Strait Islander ☐ South Sea Islander ☐

In which country were you born? (please tick ONE box, and enter name of country if born overseas)

Australia ☐ Another Country ☐ Name of Country.....

What language is spoken at home?.....

	No	Yes	If "Yes", please give details
Are you being treated by a doctor at present?			
Are you taking any tablets or medicines (prescribed or over-the-counter) at present?			
Do you normally require antibiotic cover before dental treatment?			
Have you had any abnormal reactions to local or general anaesthesia?			
Do you smoke?			
Are you pregnant? (Females Only)			

Please list any drugs or medicines you are allergic to:

Please list any other known allergies (including latex):

Who is your medical practitioner? *(Name/Address)*: .....

..... Phone: .....

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS?
(Please tick appropriate box(es))

	No	Yes		No	Yes		No	Yes
Steroid therapy			Kidney disease			Prosthetic or other implant, eg artificial hip, shunt		
Rheumatic fever			Excessive bleeding			Heart valve disorder, eg heart murmur		
Epilepsy			Heart complaint			Hepatitis or other liver diseases		
Asthma			Nervous condition			Stomach or digestive condition		
Diabetes			Tuberculosis			Contact with HIV/AIDS virus		
Cardiac pacemaker			Thyroid disease			Bronchitis, emphysema or other lung diseases		
Stroke			High or low blood pressure			Anaemia, leukaemia or other blood diseases		
Radiation therapy			Any other condition(s) *(please list)*:					

PLEASE LIST ANY PROBLEMS THAT YOU HAVE WITH YOUR TEETH OR MOUTH:

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I consent to health professionals who have treated me exchanging such information about me as may be required to assist in providing oral health care to me. I also consent to information that has been collected by Queensland Health, when providing oral health care to me, being used by Queensland Health to check and assess the oral health services I have received and how those services have been used, so long as my name is not used in any reports or published statistics.

Office use only (Checked by operator)

Your signature:..... Date: / /

MEDICAL/DENTAL HISTORY FORM

REV: FEB 2003

SDS: HQH ORAL 03 (A4)