HOPKINS DENTAL

Patient Medical Update

All information on this form is, and will remain, strictly confidential under the Privacy Act 1988

Patient Information

Surname: _____ Given names: _____

Title: _____ Date of Birth: ____ / ____ / _____ Occupation: _____

Home or Postal Address: _____ Postcode: _____

Home Phone: _____ ☐ Mobile: _____ ☐ Work Phone: _____ ☐

Email: _____ *Preferred contact for appointment reminder (please tick one)*

Emergency contact person

Name: _____

Phone: _____

Health fund information (if applicable)

Fund Name: _____

Membership No.: _____

Medical history update

Have you ever had, or do you suffer from, any of the following? Please tick ONLY those that apply:

- ☐ Anaemia/Blood disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood pressure
- ☐ Bone disease / Osteoporosis
- ☐ Brain shunt / injury / surgery
- ☐ Cancer / Chemotherapy
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive bleeding
- ☐ Fainting disorder
- ☐ Gastric banding / Lap band
- ☐ Heart disease / Murmur / Stent
- ☐ Hepatitis A / B / C
- ☐ HIV
- ☐ Immune disorders
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease
- ☐ Pacemaker
- ☐ Prosthetic
- ☐ Prosthetic implant / Joint replacement
- ☐ Psychiatric condition
- ☐ Radiation therapy
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Steroid therapy
- ☐ Stomach issues
- ☐ Stress disorders
- ☐ Stroke
- ☐ Surgery
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Tumours

How do you rate your overall GENERAL HEALTH? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

*If you respond **'yes'** to any questions in this group, **please provide more information in the space provided.***

Are you currently taking any pills, medications, or supplements? ☐ No ☐ Yes→ _____

Do you have any allergies to antibiotics, medications, or other substances? ☐ No ☐ Yes→

Have you had any serious illnesses since your last visit? ☐ No ☐ Yes→ _____

Are you expecting to undergo any surgery or treatment in the next six months? ☐ No ☐ Yes→ _____

Are you taking any medication for any bone disorder? ☐ No ☐ Yes→ _____

Do you have other medical conditions that you have not listed above? ☐ No ☐ Yes→ _____

Do you smoke cigarettes or other recreational drugs? ☐ No ☐ Yes→ *How many per day?* _____

Females please also answer these questions:

Are you currently, or do you think you might be, pregnant? ☐ No ☐ Yes→ *Likely due date?* _____

Are you currently breastfeeding? ☐ No ☐ Yes

Signature: _____ Date: / /