REDGUM
PERIODONTICS + IMPLANTS

CONFIDENTIAL

Please circle: Mr, Mrs, Ms, Miss, Mst, Dr, Prof, Other…… Surname: ……

Given Name/s…… Preferred Name: …… Date of Birth: ……/……/…….

Address: …… Postcode: ……

Contact: Home …….. Work …… Mobile ……

Email address: ……

Emergency Contact: Name …… Number ……

Referring Dentist: …… Medical Doctor: …… Health Fund: ……

MEDICAL HISTORY

Are you currently in good health? …… Have you been under a doctor's care in the last year? ……
If so, for what reason? ……
Please list all current medications: ……
……
Are you allergic to Penicillin or any other drug? ……
Have you been advised by your doctor to take antibiotics prior to dental treatment? ……
Have you had an unpleasant reaction following dental injections? ……
Do you bleed excessively following a cut or tooth extraction? ……
Are you pregnant? …… If **YES,** how many months? ……

Do you smoke? ☐ Yes ☐ No (more than 10 cigarettes per day) ☐ Yes ☐ No

Have you or have you ever had any of the following: Please ✓ **if YES**

☐ Rheumatic Fever	☐ Diabetes	☐ Arthritis
☐ High Blood Pressure	☐ Osteoporosis	☐ Epilepsy
☐ Cancer	☐ Asthma	☐ Emphysema
☐ Radiation Treatment	☐ Hepatitis. Type? ……	☐ Frequent Headaches
Location……	☐ HIV Infection	☐ Reflux

☐ Thyroid Condition – please describe:……
☐ Heart Problems/Surgery - please describe: ……
☐ Organ Transplant - please describe: ……
☐ Joint Replacement - please describe: ……
☐ Anaemia or Blood Disease – please describe: ……
☐ Deep Vein Thrombosis – please describe: ……

Signature: …… Date: ……