perio focus
SPECIALIST PERIODONTICS & IMPLANT DENTISTRY

PATIENT HISTORY MEDICAL FORM

Title: Mr / Mrs / Ms / Miss / Dr

Surname:

Given Name:

Street Address:

Suburb: Postcode:

Date of Birth: Home Phone:

Work Phone: Mobile:

Email:

Occupation: **Emergency Contact:**

Referring Dentist: **Emergency Number:**

Private Health Fund Name: **Relationship to Patient:**

Please indicate below if you have had, or have at present, any of the following:
(Please tick where appropriate)

- ☐ Artificial Joint (Hip, Knee)
- ☐ Arthritis: Osteo / Rheumatoid
- ☐ Artificial Valve / Stents
- ☐ Asthma / Hay Fever
- ☐ Bleeding Disorder eg. Haemophilia
- ☐ Cardiac Pacemaker
- ☐ Chemotherapy
- ☐ Congenital Heart Disease
- ☐ Diabetes (Type I or II)
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Heart Attack / Chest Pain
- ☐ Heart Valve Disorder
- ☐ Hepatitis A, B or C
- ☐ High / Low Blood Pressure
- ☐ HIV+
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Steroid Therapy
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Transplanted Organ / Marrow

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IMPORTANT MEDICAL INFORMATION

Do you smoke?	Yes	No	If Yes, how many per day?	How many years (Approx)?
Are you currently taking any medication, drugs or pills	Yes	No	If Yes, please list all medication and supplements:	
Are you allergic to any drugs medicines or materials?	Yes	No	If Yes, please list:	
Are you currently undergoing medical treatment?	Yes	No	Details:	
Have you had surgery?	Yes	No	Details:	
Ladies - Are you breast-feeding?	Yes	No	Are you pregnant? Yes No	Due date:

Why have you come to the practice? (Please fill in and circle where appropriate)

How did you hear about us?	Referred by dentist | Word Of Mouth | Google Search | Online Ads | Print Ads				
Pain / Tooth Sensitivity	Where: Duration:	Worsened by:	Eating	Cold or hot temp	Always
Receding Gums	Where:	How long:	Weeks	Months	Years
Bleeding Gums		How long:	Weeks	Months	Years
Loose teeth	Where:	How long:	Weeks	Months	Years
Lump or swelling	Where:	How long:	Weeks	Months	Years
How frequently would you normally attend the dentist?	1-2 Times a year	Irregularly	As little as possible		
Do you want to explore all options to save your teeth?	Yes No	Comments:			

By signing this document, you agree to abide by the following

- The medical and contact information I have provided is true, correct and accurate to the best of my knowledge. It is my responsibility to provide the staff at Perio Focus with the most current list of medications and history of medical problems.
- I absolve Dr Derrick Lee of any responsibility should I fail to provide current and accurate information on the medications, surgical procedures and medical problems or if I acted in an untruthful manner.
- I have read the Payment Policy and agree to follow the terms and conditions listed.
- I have read the Reminder & Missed Appointment/Late Cancellation Policy and agree to follow the terms and conditions listed.

Signature: **Date:**

If under 18, Parent / Guardian Name: OFFICE USE Reviewed by:

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Wembley WA 6014

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Kalamunda WA 6076

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