Ottaway DENTAL

Dr Wayne Ottaway

BDSc FADI PFA

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Medical History Form

(Circle) Dr Mr Mrs Miss Ms Surname ________________________________

First, second name _______________ , ________________ Date of Birth ____/____/____

Address ____

Suburb/Town ____________________ Post code ___________

Telephone (Home) _______________ (Mobile) __________________ (Work) _____________

Email: ____

Emergency Contact (name) ______________________________ (phone) _____________

Why did you choose our surgery? Previous/existing patient [ ] Internet [ ]

Yellow Pages [ ] Newspaper [ ] Reputation [ ] Other [ ] ___________________

(Tick any that apply)

Heart	☐Rheumatic Fever	☐High Blood Pressure	☐Heart Surgery	☐Pacemaker
	☐ Heart Murmur	☐ Angina	☐Thrombosis	☐Other __________
Chest	☐ Bronchitis	☐ Emphysema	☐ Pneumonia	☐Chest Surgery
	☐ Smoker	☐Cystic Fibrosis	☐ Pleurisy	☐Other __________
Blood	☐ Bleeding	☐Hepatitis _______	☐ HIV	☐Anaemia
	☐ Abnormal Test	☐Sickle Cell	☐ Haemophilia	☐ Other __________
Other	☐Diabetes	☐Liver Disease	☐Kidney Disease	☐ Epilepsy
	☐Cancer ________	☐GA experience	☐ Hiatus Hernia	☐Other__________
Allergies	☐Penicillin	☐Hay Fever	☐Eczema	☐Anti Tetanus serum
	☐Aspirin	☐Asthmatic	☐Latex rubber	☐Other __________
Warnings	☐Artificial Joint	☐Heart Valve	☐Bisphosphonates	☐Pregnant
	☐Antibiotic cover	☐Local Anaesthesia	☐Do Not recline	☐Other__________

Medications ☐ **no** ☐ **yes** (list) ____

____

I have completed this questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place me under medical risk.

Signed ____________________________ Date _____/_____ /______