East Keilor Dental
27 McFarlane Street, East Keilor 3033
(ph) 9337 4076
reception@eastkeilordental.com.au

Medical History Questionnaire

PERIODIC MEDICAL HISTORY REVIEW:

Full name: Mr. Mrs. Ms. Miss. Dr. _____ Date of birth: ___/___/_____

MEDICAL HISTORY:

Are you having any problems with your health? Y☐ N ☐ details _____
Have you EVER had, or been suspected of having, any of the following:

High Blood pressure	Y☐ N ☐	Stroke	Y☐ N ☐
Heart disease/murmur	Y☐ N ☐	Unusual/excessive bleeding	Y☐ N ☐
Diabetes	Y☐ N ☐	Thyroid condition	Y☐ N ☐
Bone disease (osteoporosis/Pagets)	Y☐ N ☐	Do you smoke	Y☐ N ☐
Are you pregnant (*women only*)	Y☐ N ☐	If yes, how many:	_____

Other medical issues: _____

Do you have any dental issues? _____

Have you started taking any ***new or different*** medications? Y☐ N ☐ If yes, please list below:

Medication	Dosage
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Are you taking any blood thinning medications? Y☐ N ☐ Please specify: _____

If there have been any changes to your medical history since your last appointment, please inform us.

CONSENT

I have read and understood the above questionnaire and I have answered all questions truthfully to the best of my ability. I understand that my medical and dental history will be kept private and confidential as per East Keilor Dental's privacy statement (available in the reception area and on the practice website).

Name: _____
☐ Parent/guardian
Signature: _____ Date: ___ / ___ / _____

Sighted by Dentist:_____