Dr Michael Stubbs
BDS MDS MDSc FRACDS

Specialist in Oral Medicine

CONFIDENTIAL PATIENT HISTORY FORM

Welcome to our practice. For our confidential records, and to assist in determining your treatment, please answer the following questions as accurately as possible.

Personal Details

(Please circle) **Dr Mr Mrs Miss Ms**

Surname: .....

First Name: ..... **Middle Name:** …….....

Date of Birth: ..... **Occupation:** .....

Home Address: .....

..... **Post Code:** .....

Tel: ..... **Mobile:** ..... **Fax:** .....

Email: .....

Business Address: .....

..... **Post Code:** .....

Preferred method of payment *(please circle)*

Cash Cheque Visa Mastercard Other: ……...

Name of person responsible for payment: .....

Address: .....

..... **Post Code:** .....

Emergency Contact Name: .....

Address: .....

..... **Post Code:** .....

Who recommended this practice to you? .....

Do you have Dental Insurance? Yes No

Fund Name: .....

Medical History

Have you ever had any of the following: *(Please circle)*

Rheumatic Fever	**Diabetes**	**Heart Ailment**
Epilepsy	**Kidney Disease**	**Anaesthetic reaction**
Asthma	**AIDS/HIV**	**Drug Addiction**
Excessive Bleeding	**Tuberculosis**	**High Blood Pressure**
Hepatitis/Liver	**Stroke**	**Emotional Problems**

Have you or any of your family been treated for Creutzfeldt-Jakob disease? YES / NO

Have you ever undergone neurosurgery prior to 1982 or growth hormone treatment prior to 1985? YES / NO

Do you have, or have you recently been exposed to an infectious disease? YES / NO

Do you have an artificial hip, heart valve or other prosthetic implant? YES / NO
If yes, please give details

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Are you allergic to any drugs, medicines or latex?
If yes, please list

.....

Have you ever been a patient in hospital?
If yes, please list illness/es

.....

Are you under any medical treatment or taking any medicines or tablets?
If yes, please list

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Have you ever had a serious or long standing illness?

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Name of current Doctor: .....

Address: .....

..... **Post Code:** ..... **Tel:** .....

Name of current Dentist: .....

Address: .....

..... **Post Code:** ..... **Tel:** .....

Ladies, are you or could you be pregnant? YES / NO / MAYBE

Have you ever had any problems with dental treatment? YES / NO
If yes, please describe:

…….....

……..

……..

Do you smoke or use tobacco? YES / NO

What is the purpose of your visit here today?

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…….....

I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place ME at undue medical risk. I also understand notes or radiographs (x-rays) relating to my treatment may need to be sent to other practitioners to aid them in my treatment, and give my permission for this to occur when necessary.

Signed: .....

Date: .....

Checked (Dr): .....