## Medical History Questionnaire



Welcome to Newcastle City Dental. In order to provide with total patient care we need to know your complete past and current medical history. In accordance with the Privacy Amendment Act 2004 and the Health Records and Information Privacy Act 2002, all information will be treated with strict confidentiality and only available to third parties you have consented to. Please complete accurately.

Title (Dr/Mr/Mrs/Master/Miss)	Patient Information						
Preferred Name	Title (Dr/Mr/Mrs/Ms/Master/Miss)	Gender (M/F)	– Gender (M/F)				
Address	Surname		_ Fii	rst Name			
Phone (Home)						_	
Email	Address			Post Code		_	
Occupation	Phone (Home) (M			1obile)			
Health Insurance Provider	Email					_	
Member ID	Occupation					_	
Medicare ID    Series Number      How did you hear about us? (Signage/Website/Google/Facebook/Pamphlets/Other)	Health Insurance Provider					_	
How did you hear about us? (Signage/Website/Google/Facebook/Pamphlets/Other)      Who referred you to us? (Friend/Patient/Medical Professional)      Emergency Contact    Name      Phone (Main)    (Alternate)      Medical History    (Alternate)      Medications (Prescription/Supplements)    Allergies      Condition (please circle)    Condition (please circle)      Cardiovascular system    Yes    No      (Heart murmur/valve problem/surgery)    Yes    No      High blood pressure    Yes    No      Respiratory system    Yes    No      Respiratory system    Yes    No      Bleeding    Yes    No      Respiratory system    Yes    No      Central nervous system    Yes    No      Yes    No    Cancer    Yes      Ves    No    Cancer    Yes    No      Bleeding    Yes    No    Chemotherapy/Radiation therapy)    Yes    No      Bleeding    Yes    No    Chemotherapy/Radiation therapy)    Yes    No      Infectious disease    Yes    No    Chemotherapy/Radiation therapy)	Member ID			Series Number		_	
How did you hear about us? (Signage/Website/Google/Facebook/Pamphlets/Other)      Who referred you to us? (Friend/Patient/Medical Professional)      Emergency Contact    Name      Phone (Main)    (Alternate)      Medical History    (Alternate)      Medications (Prescription/Supplements)    Allergies      Condition (please circle)    Condition (please circle)      Cardiovascular system    Yes    No      (Heart murmur/valve problem/surgery)    Yes    No      High blood pressure    Yes    No      Respiratory system    Yes    No      Respiratory system    Yes    No      Bleeding    Yes    No      Respiratory system    Yes    No      Central nervous system    Yes    No      Yes    No    Cancer    Yes      Ves    No    Cancer    Yes    No      Bleeding    Yes    No    Chemotherapy/Radiation therapy)    Yes    No      Bleeding    Yes    No    Chemotherapy/Radiation therapy)    Yes    No      Infectious disease    Yes    No    Chemotherapy/Radiation therapy)	Medicare ID			Series Number		_	
Who referred you to us? (Friend/Patient/Medical Professional)							
Who referred you to us? (Friend/Patient/Medical Professional)	How did you hear about us? (Signage/Web	site/Go	ogle/	Facebook/Pamphlets/Other)		_	
Phone (Main)    (Alternate)      Medical History    Allergies      Medications (Prescription/Supplements)    Allergies      Condition (please circle)    Condition (please circle)      Cardiovascular system    Yes    No      Physical disability    Yes    No      (Heart murmur/valve problem/surgery)    Yes    No      Intellectual disability    Yes    No      (Rheumatic Fever/Infective Endocarditis)    Yes    No      High blood pressure    Yes    No    Immune disorder    Yes    No      Bleeding    Yes    No    Renal system    Yes    No      Central nervous system    Yes    No    Liver    Yes    No      (Epilepsy)    Yes    No    Cancer    Yes    No      Mental health    Yes    No    Medication    Yes    No      Infectious disease    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Allergies    Yes    No </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
Phone (Main)    (Alternate)      Medical History    Allergies      Medications (Prescription/Supplements)    Allergies      Condition (please circle)    Condition (please circle)      Cardiovascular system    Yes    No      Physical disability    Yes    No      (Heart murmur/valve problem/surgery)    Yes    No      Intellectual disability    Yes    No      (Rheumatic Fever/Infective Endocarditis)    Yes    No      High blood pressure    Yes    No    Immune disorder    Yes    No      Bleeding    Yes    No    Renal system    Yes    No      Central nervous system    Yes    No    Liver    Yes    No      (Epilepsy)    Yes    No    Cancer    Yes    No      Mental health    Yes    No    Medication    Yes    No      Infectious disease    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Allergies    Yes    No </td <td>Free war and Countrast Norma</td> <td></td> <td></td> <td>Deletionship</td> <td></td> <td></td>	Free war and Countrast Norma			Deletionship			
Medical History      Medications (Prescription/Supplements)    Allergies      Condition (please circle)    Condition (please circle)      Cardiovascular system    Yes    No      Physical disability    Yes    No      (Heart murmur/valve problem/surgery)    Yes    No      High blood pressure    Yes    No      High blood pressure    Yes    No      Bleeding    Yes    No      Respiratory system    Yes    No      Central nervous system    Yes    No      Central nervous system    Yes    No      Central nervous system    Yes    No      Cipilepsy)    Yes    No      Cancer    Yes    No      Diabetes    Yes    No      Merdial health    Yes    No      Musculoskeletal system    Yes    No      Medication    Yes    No      Medication    Yes    No      Medication    Yes    No      Central nervous system    Yes    No      Physical disability    Yes    No				-			
Medications (Prescription/Supplements)    Allergies      Condition (please circle)    Condition (please circle)      Cardiovascular system    Yes    No    Physical disability    Yes    No      (Heart murmur/valve problem/surgery)    Yes    No    Intellectual disability    Yes    No      (Rheumatic Fever/Infective Endocarditis)    Yes    No    Immune disorder    Yes    No      Bleeding    Yes    No    Renal system    Yes    No      Respiratory system    Yes    No    Cancer    Yes    No      Central nervous system    Yes    No    Cancer    Yes    No      Mental health    Yes    No    Medication    Yes    No      Diabetes    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Allergies    Yes    No      Medical Practitioner    Name    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    A				(Alternate)		-	
Condition (please circle)    Condition (please circle)      Cardiovascular system    Yes    No    Physical disability    Yes    No      (Heart murmur/valve problem/surgery)    Yes    No    Intellectual disability    Yes    No      (Rheumatic Fever/Infective Endocarditis)    Yes    No    Immune disorder    Yes    No      High blood pressure    Yes    No    Gastro-intestinal system    Yes    No      Bleeding    Yes    No    Renal system    Yes    No      Respiratory system    Yes    No    Liver    Yes    No      Central nervous system    Yes    No    Cancer    Yes    No      Mental health    Yes    No    Pregnant    Yes    No      Diabetes    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Hospital admissions/operations    Yes    No      Musculoskeletal system    Yes    No    Smoking    Yes    No      Infe	Medical History						
Cardiovascular system    Yes    No    Physical disability    Yes    No      (Heart murmur/valve problem/surgery)    Yes    No    Intellectual disability    Yes    No      (Rheumatic Fever/Infective Endocarditis)    Yes    No    Immune disorder    Yes    No      High blood pressure    Yes    No    Gastro-intestinal system    Yes    No      Bleeding    Yes    No    Renal system    Yes    No      Respiratory system    Yes    No    Cancer    Yes    No      (Epilepsy)    Yes    No    Chemotherapy/Radiation therapy)    Yes    No      Mental health    Yes    No    Allergies    Yes    No      Diabetes    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Allergies    Yes    No      Musculoskeletal system    Yes    No    Smoking    Yes    No      Last medical visit	Medications (Prescription/Supplements)			Allergies			
Cardiovascular system    Yes    No    Physical disability    Yes    No      (Heart murmur/valve problem/surgery)    Yes    No    Intellectual disability    Yes    No      (Rheumatic Fever/Infective Endocarditis)    Yes    No    Immune disorder    Yes    No      High blood pressure    Yes    No    Gastro-intestinal system    Yes    No      Bleeding    Yes    No    Renal system    Yes    No      Respiratory system    Yes    No    Cancer    Yes    No      (Epilepsy)    Yes    No    Chemotherapy/Radiation therapy)    Yes    No      Mental health    Yes    No    Allergies    Yes    No      Diabetes    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Allergies    Yes    No      Musculoskeletal system    Yes    No    Smoking    Yes    No      Last medical visit							
Cardiovascular system    Yes    No    Physical disability    Yes    No      (Heart murmur/valve problem/surgery)    Yes    No    Intellectual disability    Yes    No      (Rheumatic Fever/Infective Endocarditis)    Yes    No    Immune disorder    Yes    No      High blood pressure    Yes    No    Gastro-intestinal system    Yes    No      Bleeding    Yes    No    Renal system    Yes    No      Respiratory system    Yes    No    Cancer    Yes    No      (Epilepsy)    Yes    No    Cancer    Yes    No      Mental health    Yes    No    Medication    Yes    No      Diabetes    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Hospital admissions/operations    Yes    No      Musculoskeletal system    Yes    No    Smoking    Yes    No      Last medical visit							
Cardiovascular system    Yes    No    Physical disability    Yes    No      (Heart murmur/valve problem/surgery)    Yes    No    Intellectual disability    Yes    No      (Rheumatic Fever/Infective Endocarditis)    Yes    No    Immune disorder    Yes    No      High blood pressure    Yes    No    Gastro-intestinal system    Yes    No      Bleeding    Yes    No    Renal system    Yes    No      Respiratory system    Yes    No    Cancer    Yes    No      (Epilepsy)    Yes    No    Cancer    Yes    No      Mental health    Yes    No    Medication    Yes    No      Diabetes    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Hospital admissions/operations    Yes    No      Musculoskeletal system    Yes    No    Smoking    Yes    No      Last medical visit							
Cardiovascular system    Yes    No    Physical disability    Yes    No      (Heart murmur/valve problem/surgery)    Yes    No    Intellectual disability    Yes    No      (Rheumatic Fever/Infective Endocarditis)    Yes    No    Immune disorder    Yes    No      High blood pressure    Yes    No    Gastro-intestinal system    Yes    No      Bleeding    Yes    No    Renal system    Yes    No      Respiratory system    Yes    No    Cancer    Yes    No      (Epilepsy)    Yes    No    Chemotherapy/Radiation therapy)    Yes    No      Mental health    Yes    No    Allergies    Yes    No      Diabetes    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Allergies    Yes    No      Musculoskeletal system    Yes    No    Smoking    Yes    No      Last medical visit							
(Heart murmur/valve problem/surgery)    Yes    No    Intellectual disability    Yes    No      (Rheumatic Fever/Infective Endocarditis)    Yes    No    Immune disorder    Yes    No      High blood pressure    Yes    No    Gastro-intestinal system    Yes    No      Bleeding    Yes    No    Renal system    Yes    No      Respiratory system    Yes    No    Liver    Yes    No      Central nervous system    Yes    No    Cancer    Yes    No      (Epilepsy)    Yes    No    Chemotherapy/Radiation therapy)    Yes    No      Diabetes    Yes    No    Medication    Yes    No      Infectious disease    Yes    No    Allergies    Yes    No      Musculoskeletal system    Yes    No    Smoking    Yes    No      Medical Practitioner    Name	Condition (please circle)			Condition (please circle)			
(Rheumatic Fever/Infective Endocarditis)    Yes    No    Immune disorder    Yes    No      High blood pressure    Yes    No    Gastro-intestinal system    Yes    No      Bleeding    Yes    No    Renal system    Yes    No      Respiratory system    Yes    No    Liver    Yes    No      Central nervous system    Yes    No    Cancer    Yes    No      (Epilepsy)    Yes    No    Chemotherapy/Radiation therapy)    Yes    No      Diabetes    Yes    No    Medication    Yes    No      Infectious disease    Yes    No    Allergies    Yes    No      Musculoskeletal system    Yes    No    Smoking    Yes    No      Medical Practitioner    Name	Cardiovascular system	Yes	No	Physical disability	Yes	No	
High blood pressure  Yes  No  Gastro-intestinal system  Yes  No    Bleeding  Yes  No  Renal system  Yes  No    Respiratory system  Yes  No  Liver  Yes  No    Central nervous system  Yes  No  Cancer  Yes  No    (Epilepsy)  Yes  No  Chemotherapy/Radiation therapy)  Yes  No    Mental health  Yes  No  Pregnant  Yes  No    Diabetes  Yes  No  Allergies  Yes  No    Infectious disease  Yes  No  Allergies  Yes  No    Musculoskeletal system  Yes  No  Smoking  Yes  No    Last medical visit	(Heart murmur/valve problem/surgery)	Yes	No	Intellectual disability	Yes	No	
Bleeding    Yes    No    Renal system    Yes    No      Respiratory system    Yes    No    Liver    Yes    No      Central nervous system    Yes    No    Cancer    Yes    No      (Epilepsy)    Yes    No    Chemotherapy/Radiation therapy)    Yes    No      Mental health    Yes    No    Pregnant    Yes    No      Diabetes    Yes    No    Allergies    Yes    No      Thyroid    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Hospital admissions/operations    Yes    No      Medical Practitioner    Name	(Rheumatic Fever/Infective Endocarditis)	Yes	No	Immune disorder	Yes	No	
Respiratory system    Yes    No    Liver    Yes    No      Central nervous system    Yes    No    Cancer    Yes    No      (Epilepsy)    Yes    No    (Chemotherapy/Radiation therapy)    Yes    No      Mental health    Yes    No    Pregnant    Yes    No      Diabetes    Yes    No    Medication    Yes    No      Thyroid    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Hospital admissions/operations    Yes    No      Medical Practitioner    Name	High blood pressure	Yes	No	Gastro-intestinal system	Yes	No	
Central nervous system  Yes  No  Cancer  Yes  No    (Epilepsy)  Yes  No  (Chemotherapy/Radiation therapy)  Yes  No    Mental health  Yes  No  Pregnant  Yes  No    Diabetes  Yes  No  Medication  Yes  No    Thyroid  Yes  No  Allergies  Yes  No    Infectious disease  Yes  No  Hospital admissions/operations  Yes  No    Medical Practitioner  Name	Bleeding	Yes	No	Renal system	Yes	No	
Central nervous system  Yes  No  Cancer  Yes  No    (Epilepsy)  Yes  No  (Chemotherapy/Radiation therapy)  Yes  No    Mental health  Yes  No  Pregnant  Yes  No    Diabetes  Yes  No  Medication  Yes  No    Thyroid  Yes  No  Allergies  Yes  No    Infectious disease  Yes  No  Hospital admissions/operations  Yes  No    Medical Practitioner  Name	-	Yes	No	-	Yes	No	
(Epilepsy)    Yes    No    (Chemotherapy/Radiation therapy)    Yes    No      Mental health    Yes    No    Pregnant    Yes    No      Diabetes    Yes    No    Medication    Yes    No      Thyroid    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Hospital admissions/operations    Yes    No      Musculoskeletal system    Yes    No    Smoking    Yes    No      Medical Practitioner    Name		Yes	No	Cancer	Yes	No	
Mental health    Yes    No    Pregnant    Yes    No      Diabetes    Yes    No    Medication    Yes    No      Thyroid    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Hospital admissions/operations    Yes    No      Musculoskeletal system    Yes    No    Smoking    Yes    No      Medical Practitioner    Name		Yes	No	(Chemotherapy/Radiation therapy)	Yes	No	
Diabetes    Yes    No    Medication    Yes    No      Thyroid    Yes    No    Allergies    Yes    No      Infectious disease    Yes    No    Hospital admissions/operations    Yes    No      Musculoskeletal system    Yes    No    Smoking    Yes    No      Medical Practitioner    Name						-	
Thyroid  Yes  No  Allergies  Yes  No    Infectious disease  Yes  No  Hospital admissions/operations  Yes  No    Musculoskeletal system  Yes  No  Smoking  Yes  No    Medical Practitioner  Name			-	-		-	
Infectious disease    Yes    No    Hospital admissions/operations    Yes    No      Musculoskeletal system    Yes    No    Smoking    Yes    No      Medical Practitioner    Name						-	
Musculoskeletal system  Yes  No  Smoking  Yes  No    Medical Practitioner  Name	-		-	-		-	
Medical Practitioner    Name      Phone							
Phone Suburb Last medical visit	wusculoskeletai system	162	INO	SHICKING	162	INO	
Phone Suburb Last medical visit	Medical Practitioner Name						
Last medical visit							

The information provided in this document is true and accurate to the best of my knowledge at the time of signing. I understand that Newcastle City Dental requires payment on the day of treatment.

Signature \_\_\_\_\_