Dr Rebecca Sun
Suite 13, 1st Floor
14-16 Brierly Street
Weston ACT 2611
(02) 6288 6866
reception@rfgdentistry.com.au
www.rfgdentistry.com.au

Patient Medical History Form

Title		**Surname**			**Given Names**		
Preferred name			**D.O.B.**		**Biological Sex**	M /F / Intersex	
Address						**Post Code**	
Home Phone		**Work**		**Mobile**		**Preferred**	
Email				**Person responsible for payment**			
Preferred method of payment	Cash ☐	Eftpos ☐	Cheque ☐	Credit Card ☐			

Medical History

Yes	No		Yes	No	
☐	☐	Heart Abnormality	☐	☐	Heart Murmur
☐	☐	Heart Valve Problems	☐	☐	Rheumatic Fever
☐	☐	Artificial Joints	☐	☐	Blood Pressure High or Low
☐	☐	Blood Pressure Medication	☐	☐	Allergy to Penicillin, Latex or Other (Specify)
☐	☐	Smoking	☐	☐	Asthma or breathing problems
☐	☐	Diabetes	☐	☐	Epilepsy, Convulsion or Dizziness
☐	☐	Cancer	☐	☐	Radiation Treatment
☐	☐	Exposure to Bisphosphonate; Osteoporosis Medication			
☐	☐	Risk of Exposure to: ☐ Hepatitis B ☐ Hepatitis C ☐ HIV (AIDS) ☐ Other serious infection or disease (please specify) _____			
☐	☐	Other Illness e.g. Liver, Kidney etc. _____			
☐	☐	Pregnant (Due date_____)	☐	☐	Breastfeeding

Please list any other medical conditions:
Please list all medications, supplements, natural remedies, recreational drugs and reasons for use:

Doctor/GP Name and Practice		**Contact Number**	
Who referred you to *rfg* Dentistry?		**When did you last see the dentist?**	
Reason for your attendance today? (e.g routine examination, pain, etc.)			
Please tick if applicable to you		**Please give a small description if applicable**	
☐	Bleeding gums		

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Patient Medical History Form

☐	Pain in jaw	
☐	Frequent headaches	
☐	Rapidly decaying teeth	
☐	Broken teeth or filling	
☐	Dry mouth	
☐	Dentures	
☐	Any crowns, bridges, implants	
☐	Any root filled teeth	
☐	Bad breath	
☐	Concerns about the appearance of your teeth or fillings	
☐	Are you having any discomfort, and can you describe it?	

Please tick if you are currently using		**Type**	**How often?**
☐	Toothbrush		
☐	Toothpaste		
☐	Floss		
☐	Other interdental aid		
☐	Other products		

Patient/Guardian signature: _____

Date: _____

Dentist signature: _____

Date sighted: _____