Dr Rick Lazar
B.D.S.(SYD), M.Sc.(LOND), M.S.(MICH.)
Prosthodontist

Medical History Form

In order to render dental treatment of a high standard, it is necessary to have the following information, which will be handled in the strictest confidence.

Mr / Mrs / Miss / Ms / Dr Given Name _____ Surname _____

Address _____ Postcode _____

Phone (Home) _____ (Work) _____ (Mobile) _____

Date of Birth / / Who referred you to this practice? _____

Private Health Insurance Company _____ Occupation _____

Medical History

Have you had any of the following? Please tick.

[ ] Rheumatic Fever
[ ] Any heart (cardiac) complaint/treatment
[ ] A cardiac pacemaker
[ ] Anti coagulant (blood thinning) medication
[ ] Blood disorders
[ ] Osteoporosis or low bone density
[ ] Diabetes
[ ] Joint replacement surgery
[ ] Excessive bleeding or bruising
[ ] Epilepsy or fits
[ ] Thyroid disease or goitre
[ ] Asthma
[ ] Any nervous system disorder
[ ] Gastric ulcer
[ ] Radiation (x-ray) therapy
[ ] Hypertension
[ ] Hepatitis
[ ] Organ transplant or bone marrow

[ ] Allergies to any foods, chemicals, substances or medicines – please specify _____

Are you under medical care at the present time? If yes, please specify. [ ] Yes [ ] No _____

Have you ever had a serious illness? If yes, please specify. [ ] Yes [ ] No _____

Are you taking any drugs, medicines, pills or tablets? If yes, please specify. [ ] Yes [ ] No _____

Do you carry any infectious disease? [ ] Yes [ ] No _____

Do you have private and confidential matters which you wish to discuss with Dr Lazar? [ ] Yes [ ] No

Do you smoke? [ ] Yes [ ] No

If yes, what do you smoke (cigarettes, cigars, pipe, other)? _____

If yes, for how long? _____ How many per day do you smoke? _____

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Dental History

What is the main reason for your visit today? _____

How long since your last dental visit? _____

Are you experiencing any discomfort in your teeth, gums, jaws or face? _____

Do you have any teeth that are sensitive to hot, cold or sweet? _____

Do your gums ever bleed when you clean your teeth? _____

Have you ever experienced any difficulty with any previous dental extractions? _____

_____

Have you ever experienced any injury to the face or jaw? _____

Do you experience any problems chewing food? _____

Do you ever experience any clicking or tenderness in or around the jaw joint and/or ear? _____

_____

Are you aware of grinding or clenching your teeth? _____

Have you had any previous orthodontic treatment, periodontal treatment or oral surgery? _____

_____

Are you unsatisfied with the appearance of your teeth? _____

How often do you clean your teeth? _____

Do you use dental floss to clean between your teeth? _____

Are you apprehensive about receiving dental treatment? _____

In signing this form I acknowledge that this represents an accurate medical history.
I will advise Dr Lazar of any changes to my medical history in the future.
I understand that all medical details will be treated with complete professional confidentiality.

Signature: _____ Date: ____/____/____