

Sienna Smiles

Considered Cosmetic Dentistry | Forrestdale, WA

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Medical History Form

Patient Details

Full Name

Date of Birth (DD/MM/YYYY)

General Health

Please indicate if you have or have had any of the following:

- Heart condition or murmur
- High or low blood pressure
- Stroke
- Diabetes (Type 1 or Type 2)
- Asthma or respiratory condition
- Epilepsy or seizures
- Bleeding disorder
- Hepatitis (A, B, or C)
- HIV/AIDS
- Kidney or liver disease
- Osteoporosis
- Cancer or radiation therapy
- Joint replacement
- Rheumatic fever
- Thyroid condition
- Mental health condition
- None of the above

Medications

Please list all medications, vitamins, and supplements you are currently taking:

Allergies

Do you have allergies to any of the following?

- Penicillin or antibiotics
- Latex
- Local anaesthetic
- Aspirin or NSAIDs
-

Other (please specify below)



No known allergies

Other allergies (please specify)

Additional Information

- I am pregnant or may be pregnant
- I smoke or use tobacco products
- I consume alcohol regularly

Is there anything else your dentist should know?

This form is confidential. Information collected is used solely for the purpose of providing dental care.