

# CONFIDENTIAL MEDICAL HISTORY UPDATE

As part of our duty of care to you, we are required to keep a current record of your medical history. The last time we updated our records was . You provided the following information. If any of this information has changed, please assist us by indicating the changes below:

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Name: Test  
Address: , , ,  
Home Phone:    Work Phone:    Other Phone:  
Occupation: .....  
Nearest Relative (Not at your address): .....  
Address: .....  
Phone: .....  
Person Responsible For Fees: .....  
Email:  
Health Fund:

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## *MEDICAL HISTORY*

Your Doctor's Name:        Telephone:  
Drugs or prescribed medicines you take regularly: None

List any changes here:  
.....  
Have you had any serious health problems in the past year Yes / No  
Allergic or (Adverse) reactions to medications or substances: None

List any changes here: .....

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Conditions that you have had , or have at present: (Please mark any changes and / or notify your dentist).

- |                                  |    |       |
|----------------------------------|----|-------|
| Heart (Surgery, Disease, Attack) | No | ..... |
| Chest Pain                       | No | ..... |
| Congenital Heart Disease         | No | ..... |
| Heart Murmur                     | No | ..... |
| High Blood Pressure              | No | ..... |
| Mitral Valve Prolapse            | No | ..... |
| Artificial Heart Valve           | No | ..... |
| Heart Pacemaker                  | No | ..... |
| Rheumatic Fever                  | No | ..... |
| Arthritis / Rheumatism           | No | ..... |
| Cortisone Medicine               | No | ..... |
| Swollen Ankles                   | No | ..... |
| Stroke                           | No | ..... |
| Diet (Special / Restricted)      | No | ..... |

Ulcers	No	.....
Diabetes	No	.....
Thyroid Problems	No	.....
Tumors	No	.....
Contact Lenses	No	.....
Emphysema	No	.....
Chronic Cough	No	.....
Tuberculosis	No	.....
Asthma	No	.....
Hay Fever	No	.....
Latex Sensitivity	No	.....
Allergies or Hives	No	.....
Sinus Troubles	No	.....
Radiation Therapy	No	.....
Hepatitis	No	.....
Blood Disease	No	.....
A.I.D.S. / HIV Positive	No	.....
Kidney & Liver trouble	No	.....
Blood Transfusion	No	.....
Artificial Joint (hip, knee, etc)	No	.....
Psychiatric / Psychological Care	No	.....
Bruise Easily	No	.....
Chemotherapy	No	.....
Nervous / anxious	No	.....
Neurological Disorders	No	.....
Epilepsy or Seizures	No	.....
Fainting or Dizzy Spells	No	.....

**Women:**

Are you **pregnant?** Yes ..... Months / No **Nursing?** Yes / No **Taking birth control pills?** Yes / No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. Station Square Dental Centre & associates will respect the confidentiality of the above information and will only contact another health care provider for further information with the patients permission unless there is an emergency. Station Square Dental Centre is compliant with all requirements of the Privacy Act as required by law. I will notify the dentist of any change in my health or medication.

**Patient / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_