ST LEONARDS DENTAL CENTRE
Dr Marlon Labalan
1st Floor Suite 104 2 Atchison Street
St Leonards NSW 2065
Tel: 9436 3347

PATIENT DENTAL AND MEDICAL HISTORY FORM

Surname:	First name:	Preferred name:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.
Date of Birth: DD / MM / YY	Sex: ❑ M ❑ F	Mobile No:	Work No:	
		Email:		

Home Address:	Street		
	Suburb:	State:	Post Code:
Postal Address ***(If different from home)***	Street		
	Suburb:	State:	Post Code:

Are you with a private health fund?	❑Yes ❑ No : If yes which health fund?

How did you hear about our practice?

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

DENTAL HISTORY

Question	Answer
When was your last dental visit?	
What is the purpose of today's visit?	
Are you pleased with the appearance for your teeth?	❑ Yes ❑ No
Do you have any tooth sensitivity or pain elsewhere in your face or jaw?	❑ Yes ❑ No

MEDICAL HISTORY

Question	Answer
Do you smoke?	❑ Yes ❑ No
Are you pregnant?	❑ Yes ❑ No
Are you currently receiving any medical treatment?	❑ Yes ❑ No
Are you currently taking any medication?	❑ Yes ❑ No Please specify
Are you *allergic* to anything / medication?	❑ Yes ❑ No Please specify

Please check any illnesses you have had or presently have:

Illness	Yes	No	Illness	Yes	No
Heart or valvular disease	❑ Yes	❑ No	Osteoporosis	❑ Yes	❑ No
High blood Pressure	❑ Yes	❑ No	Rheumatic fever	❑ Yes	❑ No
Low blood pressure	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No
Blood or bleeding disorder	❑ Yes	❑ No	Liver problem	❑ Yes	❑ No
Stroke	❑ Yes	❑ No	Kidney problem	❑ Yes	❑ No
Diabetes type 1	❑ Yes	❑ No			
Diabetes type 2	❑ Yes	❑ No			
Do you have any condition that is not listed above that we should know about?	❑ Yes	❑ No	Please specify:		

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Mobile No.: ( )	Work phone no.: ( )
Patient Signature		*Date*	