



Patient Update Details - Medical History

Patient Details – Please enter your name, DOB & best contact number

Title: _____

Surname: _____ Given name: _____ DOB: _____

Contact number: _____

- Have you changed your address or contact details in the last 2 years? Yes No Go to *Section B*

Section A

Address: _____

Suburb: _____ State: _____ Postcode: _____

Mobile: _____ Home Phone: _____

Email: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Section B

Are you completing this form on behalf of somebody else? No Yes (Please fill in the details below)

Relationship to Patient: Parent Guardian Other: _____

Surname: _____ Given Name: _____ Phone: _____

Medical History - Your medical history is important to us as it may influence our treatment approach.

GP Name: _____ GP Practice: _____ GP Phone: _____

Please be assured that any information provided is confidential and we appreciate your co-operation.

Please if you have had any of the following.

- | | | |
|--|--|---|
| <input type="checkbox"/> Abnormal/excessive bleeding | <input type="checkbox"/> Cancer | <input type="checkbox"/> Neurological disorder |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cardiac surgery/pacemaker | <input type="checkbox"/> Oral ulceration |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Prosthetic joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes type 1/type 2 | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Blood disorder (private details)
_____ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Radiation/chemotherapy |
| <input type="checkbox"/> Blood pressure (high/low) | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Blood thinner | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Bone disease (e.g. Osteoporosis) | <input type="checkbox"/> Hepatitis A/B/C/D | <input type="checkbox"/> Steroid therapy |
| <input type="checkbox"/> Current or past | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Taking medications | <input type="checkbox"/> Immune deficiency | <input type="checkbox"/> Thyroid disorder |
| | <input type="checkbox"/> Kidney/liver disease | <input type="checkbox"/> Other: _____ |

Are you a smoker? No Yes - how often? _____

Are you pregnant? No Yes - how many months? _____

Are you taking medication (including natural supplements)? No Yes (Please fill in the details below)

Allergies

Aspirin Iodine Latex Penicillin Sulpha drugs Types of metals Other: _____

Patient/Legal guardian signature: _____ Date: _____