General and Medical History Patient Information

Title	Mr ◯	Mrs ◯	Ms ◯	Dr ◯	Prof ◯	Other: ◯				
Surname						**Gender**	Male ◯		Female ◯	
First Name						**Date of Birth**	YY	YY	MM	DD
Middle Name										
Marital Status	Single ◯	Married ◯	Widowed ◯	Divorced ◯						
RSA ID#						**Passport #**				
Telephone	**(H)**			**Cellphone**						
Email										
Residential Address										
					Postal Code					
Postal Address										
					Postal Code					
Contact details of an individual who does not reside with you	**Name**									
	Telephone									
Business Name						**Occupation**				
Business Address										
						Telephone				

Medical Scheme:						**Option**				
Medical Scheme Number										
Person responsible for the account / Main member of Medical Aid										
Surname						**First Name**				
RSA ID#						**Passport #**				
Residential Address										
					Postal Code					
Details of general medical practitioner	**Name**				**Telephone**					
	Address									
Details of specialist if currently being treated by one	**Name**				**Telephone**					
	Address									
Name of person who referred you:										

MEDICAL HISTORY

What is your current physical health?	Good ◯	Fair ◯	Poor ◯	**Do you smoke or use tobacco in any form?**	Yes ◯	No ◯
Are you currently taking any medication - either prescription or over the counter medication?					Yes ◯	No ◯

Please list below the medication which you are currently taking:

Name	Strength	Frequency

Apart from the above, have you ever taken?			
Drug	**Name**	**Strength**	**Frequency**
Anti-depressants			
Bisphosphonates			
Blood Thinners			
Cortisone			
Dietary Supplements			

ALLERGIES: Please name any medication or drugs to which you have had an allergic response:	

Females	**Are you currently Pregnant?** Yes ◯	No ◯	**Are you currently using any type of birth control?** Yes ◯	No ◯
Males	**PSA count** Yes ◯	No ◯	If YES please state	

Have you ever had any of the following disease/s or medical conditions?

Heart Disease / Pacemaker	Yes ◯	No ◯	Jaundice or Liver problems	Yes ◯	No ◯
Heart attack	Yes ◯	No ◯	Fever Blisters	Yes ◯	No ◯
Heart murmur	Yes ◯	No ◯	Herpes	Yes ◯	No ◯
Heart surgery	Yes ◯	No ◯	Hepatitis A/B/C	Yes ◯	No ◯
Congenital Heart Failure	Yes ◯	No ◯	Epilepsy	Yes ◯	No ◯
Rheumatic Fever	Yes ◯	No ◯	Seizures	Yes ◯	No ◯
High or low blood pressure	Yes ◯	No ◯	Headaches (Severe or frequent)	Yes ◯	No ◯
Diabetes Type 1	Yes ◯	No ◯	Stroke	Yes ◯	No ◯
Diabetes Type 2	Yes ◯	No ◯	Hormonal Problems	Yes ◯	No ◯
Cancer	Yes ◯	No ◯	Psychiatric Problems	Yes ◯	No ◯
Chemotherapy	Yes ◯	No ◯	Artificial bones/joints/valves/ prosthesis	Yes ◯	No ◯
Radiation Treatment	Yes ◯	No ◯	Glandular Swelling	Yes ◯	No ◯
Anaemia	Yes ◯	No ◯	Tuberculosis (TB)	Yes ◯	No ◯
Blood clotting problems	Yes ◯	No ◯	Kidney Problems	Yes ◯	No ◯
Porphyria / Haemophilia	Yes ◯	No ◯	HIV/AIDS	Yes ◯	No ◯
Blood Transfusion	Yes ◯	No ◯	Glaucoma	Yes ◯	No ◯
Hay Fever / Sinus Problems	Yes ◯	No ◯	Neck Surgery	Yes ◯	No ◯
Asthma	Yes ◯	No ◯	Spinal surgery	Yes ◯	No ◯
Lung problems	Yes ◯	No ◯	Scarlet Fever	Yes ◯	No ◯
Bronchitis	Yes ◯	No ◯	Shingles	Yes ◯	No ◯
Difficulty Breathing	Yes ◯	No ◯	Ulcers	Yes ◯	No ◯
Emphysema	Yes ◯	No ◯	Drug/Alcohol abuse	Yes ◯	No ◯
Arthritis	Yes ◯	No ◯	Osteoporosis	Yes ◯	No ◯
Dizziness/Fainting spells	Yes ◯	No ◯	Parkinson Disease	Yes ◯	No ◯

Do you have any disease, condition or problem not listed above that we should be notified of?	Yes ◯	No ◯
If YES please state:		

Have you been hospitalised in the last two years?	Yes ◯	No ◯
If YES please give reason:		

DENTAL HISTORY

What is your main complaint or purpose of this visit?								
When last did you visit a Dentist?			**When last did you visit a Oral Hygienist?**					
How many times per day do you brush?			**How often do you floss?**					
Do your gums bleed when:	**Brushing**	Yes ◯	No ◯	**Flossing**	Yes ◯	No ◯		

Do you experience any of the following:			**If, YES please give details**					
Any abnormal reactions with dental injections?	Yes ◯	No ◯						
Any discomfort or pain in your mouth?	Yes ◯	No ◯						
Gums bleeding ever?	Yes ◯	No ◯						
Have you had any gum surgery?	Yes ◯	No ◯						
Have you had orthodontic treatment?	Yes ◯	No ◯						
Mouth habits (Clenching or Grinding)?	Yes ◯	No ◯						
Any tooth sensitivity?	Yes ◯	No ◯	**Heat**	Yes ◯	No ◯	**Cold**	Yes ◯	No ◯
Frequent mouth ulcers?	Yes ◯	No ◯						
Have you noticed any loose teeth?	Yes ◯	No ◯						
Have you noticed any bad breath or a bad taste?	Yes ◯	No ◯						
Pain in the joints of your jaw?	Yes ◯	No ◯						
Do you wear a denture?	Yes ◯	No ◯						

SLEEP APNEA

Do you experience any of the following:					
I often snore when I sleep?	Yes ◯	No ◯	I have headache in the morning?	Yes ◯	No ◯
I feel tired or sleepy during the day?	Yes ◯	No ◯	I find it difficult to concentrate?	Yes ◯	No ◯
I wake myself gasping for air?	Yes ◯	No ◯			

PLEASE NOTIFY US SHOULD ANY OF THE ABOVE INFORMATION CHANGE.

THE PRACTICE IS CONTRACTED OUT AND THEREFORE PAYMENT IS DUE IMMEDIATELY AFTER EACH APPOINTMENT

Date _____ Signature _____

I HEREBY CONFIRM THAT THE ABOVE IS CORRECT AND COMPLETE