MARTINA LAVERY
Dental & Skin Studio

This Form is double sided

Treatment Medical History Form

For your safety and comfort, please answer the following questions accurately. Discuss anything you are unsure of with your dentist – This information can have a serious impact on your Treatment.

Tittle *First* *Middle* *Surname*

Date of Birth Occupation

Address

Unit/Street No. *Street Name* *Suburb* *Post Code*

Mobile No. _____ Landline _____ Email _____

Health Fund _____ Fund No. _____ Ref No. _____

Local GP Contact

Name _____ Address _____ Phone no. _____

Emergency Contact

Name _____ Mobile no. _____ Relationship _____

TICK ONLY if you experience, or have experienced in the past, and provide details;

- ☐ Allergies……
- ☐ Severe Allergy, Anaphylaxis, gram Positive Bacterial Infection or Botulism
- ☐ Herpes……
- ☐ Neuromuscular Disorders – e.g. Myasthenia Gravis, Eaton-Lambert Syndrome, Multiple Sclerosis
- ☐ Skin Cancer or Other Skin Conditions e.g. Psoriasis, Acne ……
- ☐ Keloid / Hypertrophic Scarring
- ☐ Communicable Disease, such as HIV, AIDS, Hep B etc
- ☐ Adverse Drug Reactions; Please List ……
- ☐ Any Other Medical Conditions / Details ……

TICK ONLY if you have/require any of the following;

- ☐ Any Heart Problems……
- ☐ **Require Prophylactic Antibiotic Cover Prior to Dental Treatment (Your doctor would have made you aware of this)**
- ☐ Hip/ Knee Replacements……
- ☐ Have Any Problems with Your Bones……
- ☐ Take Any Oral Infusion Medications for Osteoporosis……

(*NB* This is Very Important as can Have Serious Complications after Tooth extractions)

TICK ONLY if you are taking any of the following or have taken them in the last 3 months. Provide Details;

- ☐ Antibiotics – Notably Spectinomycin, Gentamycin, Clindamycin……
- ☐ Non-Steroidal Anti-Inflammatory Drugs (NSAIDS): ……
- ☐ Anti-Coagulant Therapy – e.g. Warfarin, Heparin, Aspirin: ……
- ☐ Health Supplements – e.g. Vitamin E, Omega – 3 Fish oils: ……
- ☐ Corticosteroids. Muscle Relaxants, Sleeping Tablets: ……
- ☐ Blood Pressure Medications: ☐ High…… ☐Low……
- ☐ Blood Thinning Medications: ……
- ☐ Any Other Medications e.g. Roaccutane ……

Female Patients ONLY – Are you Currently ☐ Breastfeeding or ☐ Pregnant

Skin

Have you previously received any of the following? If so, list date, product, dosage and any problems;
Botox / Dysport / Dermal Filler Injections / Facial Treatments – e.g. Laser, Micro-dermabrasion:

Do you Apply Sunscreen Every day? _____

Do you have any Concerns with your skin? _____

Dental

Do You Have Any Concerns with Your Teeth? If So Please Specify.

Do You Have Sensitive Teeth? If so Please Specify if Sensitive to Hot, Cold, Sweet…

Do You Have Any Missing Teeth? If so Please Specify. (Does this Concern You?)

Do You Have Any Joint or Face Pain? If So Please Specify.

Do You Have Any Wear on Your Teeth That Concerns You? If So Please Specify.

Are You Happy with Your Smile? Would You Like to Improve it? How?

About Your Sleep

Have you been told that you snore?	Yes ☐	No ☐
Have You Been Told That You Stop Breathing During Your Sleep?	Yes ☐	No ☐
Do You Often Feel Excessively Sleepy During the Day?	Yes ☐	No ☐

How Did You Hear About Us?
……

Would You Like to Receive Newsletters and Promotions from Us? ☐ YES ☐ NO

Patient/Guardian Signature _____ Date _____

Dr Martina Lavery Signature _____ Date _____

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Review us on Google
★★★★★
Had a Great Experience? Review Us on Google