Adelaide Dental

Dr. George Mandranis & Dr. Graham Parry
Dental Surgeons

Affix patient sticker here.

Welcome back to our practice!
THIS INFORMATION IS CONFIDENTIAL and is necessary to enable us to offer you THE BEST POSSIBLE CARE. It is now mandatory to have a written updated medical history every 2 years and we would appreciate your time in thoroughly completing this form.

Are you currently or have you taken any prescribed medication or dietary supplements in the last 12 months? **YES/NO**
(If YES, please list below)

Allergies / Reactions? If YES, please list below **YES / NO**

Have you **ever had** or are you **suffering** from any of the following? Please tick any that apply:

- ❑ Rheumatic fever
- ❑ Epilepsy
- ❑ Asthma
- ❑ Tuberculosis
- ❑ Radiation Therapy
- ❑ Dizziness, fainting
- ❑ Hepatitis A B or C
- ❑ Recent eye surgery
- ❑ Diabetes
- ❑ Kidney Disease
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ Bleeding problems
- ❑ Artificial joints
- ❑ Respiratory problems
- ❑ HIV Positive
- ❑ High cholesterol
- ❑ Cancer
- ❑ Pace-maker
- ❑ Osteoporosis
- ❑ Heart rate problems
- ❑ Heart murmur

Do you have any disease, condition or problem not listed above? **YES / NO**

Have you had surgery or been to hospital in the last 5 years? (if YES, please give details) **YES / NO**

For Women: Are you pregnant? If yes, how many months? **YES / NO**

Do you currently or have you ever smoked? **YES / NO**

The information that I have provided is to the best of my knowledge true and correct and I understand that it is my responsibility to inform of any changes in my medical status.

Patient/Parent/Person Responsible Signature: _____ Date: _____