DR'S JANEL WELGEMOED, HANNESKE CORNELISSEN
ORAL HYGIENIST'S NASIMA HAMDULAY + TANIAN GOLIATH.

LONGBEACH DENTAL

PATIENTS MEDICAL HISTORY

Health Professional Council of South Africa requires that Medical History Forms be updated every 6 months

Patient Name & Surname: …… **Email Address:** ……

Home Address: …… **Cell No:** ……

Please tick YES or NO					
Heart problems? Heart valve replaced? Do you have a pacemaker?	YES	NO	Stomach Ulcers	YES	NO
High Blood Pressure?	YES	NO	Asthma?	YES	NO
Bleeding Problems?	YES	NO	Tuberculosis?	YES	NO
Are you taking any Blood thinners? Aspirin, Warfarin, Ecotrin, Plavix or name tablet.	YES	NO	Porphyria?	YES	NO
Rheumatic Fever?	YES	NO	Epilepsy?	YES	NO
Hip / Knee replacement	YES	NO	Ladies – Pregnant?	YES	NO
Osteoporosis	YES	NO	Sexually transmitted disease?	YES	NO
Bisphosphonate Treatment	YES	NO	HIV Positive?	YES	NO
Diabetes?	YES	NO	Are you a smoker?	YES	NO
Had radiation or chemotherapy?	YES	NO	Any reaction to injections?	YES	NO
Hepatitis?	YES	NO	Had surgery?	YES	NO

Allergies and any other illness?

……

Any medication?

……

……

Medical Doctor's Name and Number ……

Patient Signature: ……

Date: …… **Dr / OH Sign**: ……

Please tick YES or NO		
Do you give Longbeach Dental permission to send you SMS appointment reminders?	YES	NO
Are you interested in tooth whitening?	YES	NO

DR'S JANEL WELGEMOED, HANNESKE CORNELISSEN
ORAL HYGIENIST'S NASIMA HAMDULAY + TANIAN GOLIATH

LONGBEACH DENTAL

PATIENTS MEDICAL HISTORY

Health Professional Council of South Africa requires that Medical History Forms be updated every 6 months

Patient Name & Surname: …… **Email Address:** ……..

Home Address: …… **Cell No:** ……..

Please tick YES or NO					
Heart problems? Heart valve replaced? Do you have a pacemaker?	YES	NO	Stomach Ulcers	YES	NO
High Blood Pressure?	YES	NO	Asthma?	YES	NO
Bleeding Problems?	YES	NO	Tuberculosis?	YES	NO
Are you taking any Blood thinners? Aspirin, Warfarin, Ecotrin, Plavix or name tablet.	YES	NO	Porphyria?	YES	NO
Rheumatic Fever?	YES	NO	Epilepsy?	YES	NO
Hip / Knee replacement	YES	NO	Ladies – Pregnant?	YES	NO
Osteoporosis	YES	NO	Sexually transmitted disease?	YES	NO
Bisphosphonate Treatment	YES	NO	HIV Positive?	YES	NO
Diabetes?	YES	NO	Are you a smoker?	YES	NO
Had radiation or chemotherapy?	YES	NO	Any reaction to injections?	YES	NO
Hepatitis?	YES	NO	Had surgery?	YES	NO

Allergies and any other illness?

……

Any medication?

……

……

Medical Doctor's Name and Number ……

Patient Signature: ……

Date: …… **Dr / OH Sign:** ……

Please tick YES or NO		
Do you give Longbeach Dental permission to send you SMS appointment reminders?	YES	NO
Are you interested in tooth whitening?	YES	NO