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DR. GUSTAV ERLANK
GENERAL DENTIST

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PATIENT NAME AND SURNAME: _____

PATIENT D.O.B.: _____ **MALE / FEMALE:** _____ **FILE NO:** _____

DISEASE / CONDITION / OPERATION / MEDICATION	**YES**	**NO**	**DON'T KNOW**
Heart Conditions / Heart Operations / Pacemaker			
High Blood Pressure			
Heart valve problems or replacements / rheumatic fever			
Blood vessel conditions/operations – stroke/shunts blood clots/ thrombosis			
Prolonged bleeding following injury			
Blood sugar problems / Diabetes			
Allergies (penicillin/ dental injections/ iodine/ latex, other)			
Jaundice / Hepatitis			
Lung and breathing problems (asthma, tuberculosis, other)			
Joint replacement (e.g. knee, hip or other) / Arthritis			
Seizures, fits and faints / Epilepsy			
Sudden weight loss (more than 5kg) / diarrhoea			
Swollen glands (Neck, groin, armpits)			
Cancer Therapy: specify (chemotherapy / radiation / surgery)			
Do you smoke? If yes, how many a day?			
HIV status			
Sinus problems / mouth ulcers / fever blisters			
Anaesthetic complications			
Other diseases / conditions: Please specify			
Do you wear a Medic Alert bracelet			
FEMALES ONLY			
Are you pregnant?			
Do you use contraceptives / hormonal injections / other?			

Are you using or did you use one of the following medications? (mark with an X)

Stimulants	Sleeping pills / Sedatives	Anti-depressants	Antibiotics	Cortisone	Blood thinners Disprin/ Warfarin/ Compral/ Grandpa

Name all medicine, homeopathic remedies or other substances you are currently using / recently used

_____

Please state any current / recent on important medical treatment:_____

_____

_____ _____

PATIENT SIGNATURE **DATE**