

Confidential

Medical History

Title.....
 Full Name.....
 DOB.....
 Address.....

 Post Code.....
 Home Tel.....
 Work/Mobile.....
 Occupation.....

 Name and address of your doctor.....

Expectant Mother: Yes / No

Last visit to the dentist.....

Are You:

Attending or receiving treatment from a doctor, hospital, clinic or specialist? Y/N

Taking any medicines from your doctor? Y/N

Taking or have you taken steroids in the last 2 years? Y/N

Allergic to any medicines, food or materials? Y/N

Have You: Y/N

Had rheumatic fever? Y/N

Had jaundice, liver/kidney disease? Y/N

Ever been told you have a heart murmur or heart problem, angina, high blood pressure, or heart attack? Y/N

Had any recent blood tests/ inoculations? Y/N

Ever had blood refused by the blood transfusion service? Y/N

Had a bad reaction to general or local anaesthetic? Y/N

Had a joint replacement? Y/N

Been hospitalised? Y/N

Any disabilities that we should know of? Y/N

Do you:

Have arthritis? Y/N

Have a Pacemaker, or have you had any form of heart surgery? Y/N

Suffer from hay-fever, eczema, or any other allergy? Y/N

Suffer from bronchitis, asthma, or any other chest condition? Y/N

Have fainting attack, giddiness, blackouts or epilepsy? Y/N

Have diabetes or anybody in your family? Y/N

Bruise easily, or following a tooth extraction/surgery/serious injury have bled as to cause you to be worried? Y/N

Carry a warning card? Y/N

Ever get cold sores? Y/N

Smoke currently or in the past? Y/N

Drink more than 14 units (female) of 20 units (male) of alcohol a week? Y/N

Have any infectious diseases? Y/N

Have or could have CJD/ Hepatitis/ HIV/ TB? Y/N

Have any other information or any cause for concern about your health that the dentist should know about? Y/N

Details:

Please List medication taken and their doses below:

Signed.....

Date.....

