dental32

Confidential medical History

To offer the best and most appropriate dental care please provide us with as much detail as possible about your medical history.

Please complete all questions.

How did you hear about the practice? ☐ Friend/Family ☐ Referral Card ☐ Internet/Website

If other please can you tell us ____

Title:________Full Name:____

Date of Birth: ____

Address:____

Postcode:____

Tel no: ____________________Mobile No: _________________________________

Email:____

Tick ☐ if you would not like to be contacted via email for practice appointments/ recalls/ news and promotions.

Occupation:____

Name of your Doctor:____

Address:____

Are You:	Circle	Details
Receiving treatment from your doctor or hospital?	Yes/No	____________
Taking any medication?	Yes/No	____________
(e.g. tablets, oinments, inhalers - including contraceptives and hormone replacement therapy)		
Please list medication below:		

Have You:	Circle	Details
Any allergies (eg penicillin, substances (eg latex, rubber)or Foods?	Yes/No	____________
Heart problems, heart surgery, angina, blood pressure problems or stroke?	Yes/No	____________
had rheumatic fever or chorea?	Yes/No	____________
had liver disease (eg jaundice, hepatitis)or kidney disease?	Yes/No	____________
asthma, bronchitis, or other chest conditions?	Yes/No	____________
Ever had a bad reaction to general or local anaesthetic?	Yes/No	____________
Arthritis?	Yes/No	____________
A joint replacement or other implant?	Yes/No	____________
Any other serious illness?	Yes/No	____________
Are you an expectant mother?	Yes/No	____________

Do You:	Circle	Details
Experience fainting attacks, giddiness, blackouts or epilepsy?	Yes/No	____________
Carry a medical warning card?	Yes/No	____________
Bruise or bleed excessively following injury, tooth extraction or surgery?	Yes/No	____________
Smoke any tobacco products now(or in the past)?	Yes/No	____________
Regularly drink more than 21 units of alcohol per week?	Yes/No	____________
Suffer from infectious diseases(incl HIV+ hepatitis)?	Yes/No	____________
Are you diabetic(or anyone in your family)?	Yes/No	____________
Is there any other information which your dentist might need to know about, such as self-prescribed medicines(eg aspirin)?	Yes/No	____________
Take any steroids or receiving any treatment for cancer (chemo/radio) or osteoporosis?	Yes/No	____________

Signature:______________________________________ Date:______________