Patient Medical History and Contact Details

Mr, Mrs, Miss, Ms, Other…….. **Full Name**…….. **Date of Birth** ……..

Address…… **Post Code**……

Work Tel…… **Home** …… **Mobile**……

E-mail address…….. **Ethnic Origin** ……..

GP Name, Address & Contact Details ……..

How long is it since you last saw a dentist? …… **Occupation**……

Do you have an objection to receiving your recall or mailing from us by e-mail or text message? YES / NO

Please complete the Medical History form below to make sure that the information we have about you is correct.

QUESTIONS	**YES**	**NO**
Are you currently Pregnant?		
Are you currently receiving treatment from a doctor, hospital or clinic?		
Are you currently taking any prescribed medicines (e.g. tablets, ointments or inhalers, including contraceptives and hormone replacement therapy)?		
Are you carrying a warning card?		
Do you suffer from allergies to any medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods?		
Do you suffer from Hay fever or eczema?		
Do you suffer from bronchitis, asthma or other chest conditions?		
Do you suffer from fainting attacks, giddiness, blackouts or epilepsy?		
Do you suffer from heart problems, angina, blood pressure, or stroke?		
Are you diabetic (or is anyone in your family)?		
Do you suffer from arthritis?		
Do you suffer from bruising or persistent bleeding following injury, tooth extraction or surgery?		
Do you suffer from any infections diseases (including HIV and hepatitis)?		
Have you ever had rheumatic fever or chorea?		
Have you ever had liver disease (e.g. Jaundice, hepatitis) or Kidney disease?		
Have you ever had any other serious illness?		
Have you ever had blood refused by the Blood Transfusion Service?		
Have you ever had a reaction to general or local anaesthetic?		
Have you ever had a joint replacement or other implant?		
Have you ever had treatment that required you to be in hospital?		
Have you ever had heart surgery?		
Have you ever had brain surgery?		
Did you receive growth hormone treatment before the mid 1980's?		
Do you have any close relatives (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob disease?		
Do you regularly drink more than 2 – 3 units (women) or 3 - 4 units (men) of alcohol per day?		
Do you smoke any tobacco products now (or did you in the past)?		
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)?		
Is there any other information which your dentist might need to know about, such as self-prescribed medicines (e.g. aspirin)?		
Epilepsy		
Have you a disability or learning difficulty		
Some of our dental chairs have a weight capacity of 18stone. If you are over this weight please tick yes.		

Please list any tablets or medicines that you take and give any other information that you think may be relevant

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None of the information that you have given us will be shared with a third party. SIGNED …… Date……