Medical History

Like all dentists we ask our patients for information about their general health to help us treat them safely. Please answer the questions below and sign the form at the bottom. We will routinely ask if there have been any changes to this information. Everything written on this sheet will be kept strictly confidential.

Name
Date of Birth
Address

Occupation
Doctor's name and address

Are you currently	Y	N	Details
Pregnant ?			
Receiving treatment from a doctor or hospital ?			
Taking any medicines/ inhalers including contraceptives/HRT			
Carrying a medical warning card ?			
Do you suffer from:			
Allergies ?			
Hayfever or eczema?			
Bronchitis, asthma or other chest problems?			
Fainting attacks, blackouts, epilepsy?			
Heart problems, angina, blood pressure problems or stroke?			
Diabetes? Or family?			
Arthritis?			

Bruising or persistent bleeding?			
Infectious diseases (including HIV and hepatitis)?			
Have you ever had:			
Rheumatic fever?			
Liver or kidney disease?			
Any other serious illness?			
A bad reaction to local or general anaesthetic?			
A joint replacement?			
Treatment that required you to stay in hospital?			
Heart surgery?			
Brain surgery?			
Growth hormone treatment(pre 1990)			
A close relative with CJD?			

How many units of alcohol do you drink per week?
(A unit is half a pint of lager, a single measure of spirits or a small glass of wine)

Do you smoke any tobacco products now (or did you in the past)?
How much per day?

Do you chew tobacco, pan or use gutkha or supari (or did you in the past)?
How much per day?
Is there anything else we ought to know about your general health?

Form completed by: (self/parent/carer)

Signature: