MEDICAL HISTORY FORM

Title……… Surname……………….. First name………………………
Date of Birth…………Sex: Male/Female
Address……………………………………………………………
……………………………………………Postcode……………………
Tel No(home)……………………..Work…………………………………
Mobile……………………………….
Occupation…………………………………………………………
Doctor's name and address………………………………………….......
…………………………………………………………………………..
How long since you last visited a Dentist?...

Certain medical conditions can affect dental treatment and vice versa

Please complete this form by ticking the appropriate boxes and answering the questions

Are you?	**Yes**	**No**
Attending or receiving treatment from any doctor?		
Taking any medicines or tablets from your doctor? If yes can we please have a copy of your prescription.		
Taking or have you taken any Steroids in the last 2years?		
Allergic to any medicines, foods or materials?		
Likely to be pregnant?		

Have you?

Ever had jaundice, liver or kidney disease, or hepatitis?		
Ever had rheumatic fever or been told that you have a heart murmur?		
Ever been told that you have a heart problem or had a heart attack?		
Ever had infective endocarditis, or a heart valve replacement or any form of heart surgery?		
High or low blood pressure?		
Had any blood tests recently?		
Ever had a bad reaction to a local or general anaesthetic?		
Ever had a stroke?		
Ever had a major operation any joint replacements or recently hospital treatment?		
Ever had your blood refused by the blood transfusion service?		
Ever been diagnosed or suspected as having V CJD or being HIV positive.		

Do you?	**Yes**	**No**
Have a pacemaker?		
Suffer from bronchitis or asthma?		
Bruise easily or have you ever bled excessively?		
Have fainting attacks, giddiness or epilepsy?		
Have diabetes?		
Carry a medical warning card? Warfarin, steroids?		
Smoke and if yes how many a day?		
Drink alcohol and if yes how many units a week?		

If 'yes' to any questions please supply details in 'notes' below or use back of the form.

Notes:…………………………………………………………………………
…………………………………………………………………………
…………………………………………………………………………
…………………………………………………………………………

If you are not sure of any of the questions, or if your medical cicumstances change, please inform the Dental Surgeon.

Are there any other aspects of your health that you feel we should know about?
List of medicines and tablets.

Patients signature……………………………… Date…………………….

Date of review	**Changes advised**	**Patients signature**
Any changes? **Yes** □ **No**□		**Dentists signature**

Date of review	**Changes advised**	**Patients signature**
Any changes? **Yes** □ **No**□		**Dentists signature**

Date of review	**Changes advised**	**Patients signature**
Any changes? **Yes** □ **No**□		**Dentists signature**

Date of review	**Changes advised**	**Patients signature**
Any changes? **Yes** □ **No**□		**Dentists signature**