High Street Dental Practice Medical History Form

Title .... Surname .... First name..

Date of Birth.. Sex: Male/Female
Address ....
....
Postcode ....

Tel.number: Home........................... Work.........................Mobile....................................

Email address...

Occupation...
Your Doctor's name and address...
....

How long since you last visited a Dentist?...

Are You?	**Yes**	**No**
Attending or receiving treatment from any doctor?		
Taking any medicines or tablets from your doctor?		
Taking or have you taken any steroids in the last two years?		
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 replaced 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 or recently received 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?		
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 warning card?		
Smoke and if yes how many a day?		
Drink alcohol and if yes how many units a week?		

CONTINUED OVERLEAF

Are there any other aspects of your health that you feel we should know about?

List of Medicines and Tablets.

Signed: Date