Medical History Form

Surname (Mr/Mrs/Miss/Ms) ______________________

Forename ______________________

Address ______________________

______________________ Postcode ______________________

Tel. No. (Home) ______________________ Tel. No. (Mobile) ______________________

Date of Birth ______________________ Occupation ______________________

Doctor's Name and Address

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Certain medical conditions can affect dental treatment and vice versa.Please complete this form by ticking the appropriate boxes and answering the questions

All details will be strictly confidential

Rheumatic fever	☐ Yes	☐ No	
Any heart complaint, heart surgery or stroke	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Epilepsy or fainting attacks	☐ Yes	☐ No	
Chronic bronchitis or asthma	☐ Yes	☐ No	
Hepatitis	☐ Yes	☐ No	
Excessive bleeding	☐ Yes	☐ No	
High blood pressure	☐ Yes	☐ No	
Any other serious illness	☐ Yes	☐ No	
Do you carry a medical warning card	☐ Yes	☐ No	
Are you allergic to any medicine, tablets or subst	☐ Yes	☐ No	
Are you at present taking any medicine or tablets	☐ Yes	☐ No	
Are you pregnant	☐ Yes	☐ No	
In the past 2 years have you			
undergone any operations	☐ Yes	☐ No	
been treated with hydro-cortisone or corticosteroids	☐ Yes	☐ No	
Other details			
Have you ever had a joint replacement operation	☐ Yes	☐ No	
Do you have a close relative who has or has had CJD	☐ Yes	☐ No	
Were you treat with growth hormone before the mid 1980s	☐ Yes	☐ No	
Have you ever had brain surgery	☐ Yes	☐ No	
Are you HIV positive	☐ Yes	☐ No	
What is your average weekly consumption of alcohol	☐ Yes	☐ No	
If you smoke, what is your average weekly consumption	☐ Yes	☐ No	

Additional Notes ______________________

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

Patient's signature ______________________ Date ______________________