Completed by Patient/ Parent / Guardian

(please circle as appropriate)

Signature Date

|  |  |  |
| --- | --- | --- |
| Date | Changes in Medical History | Dentist Signature |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Surname

First Name(s)

Title Mr/Mrs//Ms/Miss/Dr Sex M/F Date of birth Day Month Year

Address

Postcode

Telephone

Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation

Doctor’s Name and Address

Doctor’s telephone number

Person to contact in an emergency

Name Relationship

Contact number

|  |  |  |  |
| --- | --- | --- | --- |
| **Are You Currently** | Yes | No | Details |
| Receiving treatment from a doctor, hospital or clinic? |  |  |  |
| Taking any prescribed medicines ? (eg tablets ointments, injections or inhalers including contraceptives and HRT) |  |  |  |
| Carrying a medical warning card? |  |  |  |
| Pregnant? |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you suffer From** | Yes | No | Details |
| Allergies to any medicines, foods or substances? |  |  |  |
| Hay Fever or Eczema? |  |  |  |
| Bronchitis, asthma or other chest condition? |  |  |  |
| Fainting attacks, giddiness, blackouts or epilepsy? |  |  |  |
| Heart Problems, angina, blood pressure problems or stroke? |  |  |  |
| Diabetes (or does any family member)? |  |  |  |
| Arthritis? |  |  |  |
| Bruising or persistent bleeding following injury, tooth extraction or surgery? |  |  |  |
| Any infectious disease (including HIV and Hepatitis? |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Have you ever had** | Yes | No |  |
| Rheumatic Fever or Chorea? |  |  |  |
| Liver disease (eg jaundice, hepatitis) |  |  |  |
| Kidney disease? |  |  |  |
| Any other serious illness |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Did you, as a child or since, have** | Yes | No | Details |
| Blood refused by the blood transfusion service? |  |  |  |
| A bad reaction to general or local anaesthetic? |  |  |  |
| A joint replacement or other implant? |  |  |  |
| Treatment that required you to be in hospital? |  |  |  |
| Heart Surgery? |  |  |  |

**Drinking**

How many units of alcohol do you drink in the average week?....................

(a unit is half a pint of larger, a single measure of spirit or a single glass of wine)

**Smoking and Tobacco products.**

Do you currently smoke? Y / N If yes how many a day?..........................

Have you previously smoked? Y / N If yes when did you stop? .................

Do you chew tobacco, pan, use gutkha or supari? Y / N

If yes how many times a day? ...........................

**Please give any other details which your dentist might need to know about, such as self prescribed medicines (eg aspirin)**

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