The Dental Centre - Medical History Form

To obtain the best and safest treatment for you, your dentist needs to know all aspects of your health which may affect your treatment. Please complete this form, which your dentist will discuss fully with you before commencing treatment. If you have any questions, please ask your dentist. Additional notes may be written on the back cover. All information will be kept completely confidential. Thank you for your co-operation.

Surname:	Forenames:
Date of Birth:	Male/Female (please circle)
Address:	Occupation:
	Telephone Home:
Postcode:	Telephone Work:
Email Address:	Mobile:
Date of last dental treatment:	
Doctor's name and address:	

ARE YOU CURRENTLY:	**YES**	**NO**	**IF YES, PLEASE GIVE DETAILS**
Receiving treatment from a doctor, hospital or clinic?			
Taking any regular/prescribed medication?			
Pregnant or possibly pregnant?			
Carrying a medical warning card?			
HAVE YOU EVER SUFFERED FROM:	**YES**	**NO**	**IF YES, PLEASE GIVE DETAILS**
Allergies to any medicines (eg antibiotics), substances (eg latex/rubber) or foods?			
Diabetes?			
Hay fever or eczema?			
Fainting attacks, giddiness, blackouts or epilepsy?			
Bronchitis, asthma or other chest condition?			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases including HIV or hepatitis?			
Heart problems, angina, blood pressure problems, stroke or pacemaker?			
A bad reaction to general or local anaesthetic?			
Rheumatic fever or chorea (St Vitus Dance)?			
Liver disease (E.g. jaundice, hepatitis) or kidney disease?			
Any other serious illness or infectious disease?			
Blood refused by the Blood Transfusion Service?			
A joint replacement or other implant?			
Treatment that required you to be in hospital?			
Heart surgery?			
Brain surgery?			
SMOKING	**YES**	**NO**	**HOW MANY?**
Do you smoke?			
ALCOHOL			
How many units of alcohol do you drink per week? (A unit is a half pint of lager, a single measure of spirits)			

Completed by: Self/Parent/Guardian (Please circle)

Signature: Date:

MEDICAL HISTORY UPDATE

Have there been any changes in your health, medicines, injections or tablets since your last course of treatment?

Date Date Date Date Date