

Medical History Form

STRICTLY CONFIDENTIAL

SURNAME: _____ FORENAMES: _____ DATE OF BIRTH: _____

ADDRESS: _____ POSTCODE: _____

OCCUPATION: _____ LAST DENTAL VISIT: _____

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

HAVE YOU SUFFERED FROM? (please delete as necessary)

Rheumatic Fever?	YES <input type="radio"/> NO <input type="radio"/>	Chronic Bronchitis or Asthma?	YES <input type="radio"/> NO <input type="radio"/>
Have you been treated with steroids in the past two years?	YES <input type="radio"/> NO <input type="radio"/>	Have you been tested positive for Hepatitis B, Hepatitis C, CJD or HIV?	YES <input type="radio"/> NO <input type="radio"/>
Any Heart Complaint?	YES <input type="radio"/> NO <input type="radio"/>	Excessive Bleeding after cuts, injuries or dental extractions?	YES <input type="radio"/> NO <input type="radio"/>
If 'yes' to any of the above, have you had heart surgery, or a pacemaker fitted?	YES <input type="radio"/> NO <input type="radio"/>	Have you ever had blood refused by the Blood Transfusion Service?	YES <input type="radio"/> NO <input type="radio"/>
Are you pregnant or breast-feeding?	YES <input type="radio"/> NO <input type="radio"/>	High Blood Pressure?	YES <input type="radio"/> NO <input type="radio"/>
Have you had a joint replacement operation?	YES <input type="radio"/> NO <input type="radio"/>	Do you carry a medical warning card?	YES <input type="radio"/> NO <input type="radio"/>
Epilepsy?	YES <input type="radio"/> NO <input type="radio"/>	Any other serious illnesses?	YES <input type="radio"/> NO <input type="radio"/>
Are you currently taking any medicines or tablets?	YES <input type="radio"/> NO <input type="radio"/>	Are you a smoker?	YES <input type="radio"/> NO <input type="radio"/>
Diabetes?	YES <input type="radio"/> NO <input type="radio"/>	How many per day	<input type="text"/>
Are you allergic to any medication, tablets or antibiotics?	YES <input type="radio"/> NO <input type="radio"/>	How many units of alcohol per week do you have?	<input type="text"/>

Please enter details of any 'yes' answers:

Name and surgery of doctor (GP): _____

Signature: _____ Today's Date: _____