2 Woodlands Parade, Main Road,
Hockley, Essex SS5 4QU

T 01702 203177
E hds@hockleydental.co.uk

www.hockleydental.co.uk

HOCKLEY DENTAL SURGERY

MEDICAL HISTORY

STRICTLY CONFIDENTIAL

Welcome to Hockley Dental Surgery. You will shortly be going through to see your dentist/hygienist. Before you do, we ask that you take a few moments to complete the questions on this from.

LIFESTYLE	*Yes*	*No*	*Please provide as much information as possible*
Do you smoke / use smoking alternatives? If so, how many per day?			
Do you drink alcohol? How many units of alcohol do you drink per week? (A unit of alcohol is a single measure of spirits, a glass of wine/aperitif, or a half pint of beer/lager)			
Is your diet high in sugar/or high frequency?			
Do you drink a lot of fizzy or acidic drinks?			
Do you use recreational drugs?			
Are you or could you be pregnant?			
Is there anything else your dentist should know about your lifestyle?			

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HDS
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HEART	*Yes*	*No*	*Please provide as much information as possible*
Rheumatic Fever			
Heart Murmur			
High/Low Blood Pressure			
Angina			
Heart Surgery			
Thrombosis			
Pacemaker fitted			
Other Heart Conditions			

BLOOD	*Yes*	*No*	*Please provide as much information as possible*
Hepatitis A, B, C, D			
Anaemia			
H.I.V / AIDS			
Sickle Cell			
Abnormal Blood Test			
Haemophilia			
Blood refused by transfusion service			
Do you take blood thinning medication such as Warfarin or Aspirin? Do you know your most recent INR?			
Other Blood Condition			

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ALLERGIES	*Yes*	*No*	*Please provide as much information as possible*
Penicillin			
Latex			
Hay Fever			
Medicine			
Anti-tetanus			
Plants			
Eczema			
Food			
General Anaesthetic			
Aspirin			
Local Anaesthetic			
Other Allergy			

WARNINGS	*Yes*	*No*	*Please provide as much information as possible*
Do you have a hearing or sight impairment?			
Do you have a problem being reclined?			
Do you require Antibiotic Cover?			
Have you had steroids in the last 2 years?			
Do you have bruising or persistent bleeding after injury, surgery, or tooth extraction?			
Do you carry a Warning Card?			
Are you currently having treatment from a doctor, hospital or clinic?			
Have you ever had treatment that required you to be hospitalised?			

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CHEST	*Yes*	*No*	*Please provide as much information as possible*
Bronchitis			
Emphysema			
Cystic Fibrosis			
Pneumonia			
Pleurisy			
Chest Surgery			
Asthma			
Other Chest Condition			

OTHER	*Yes*	*No*	*Please provide as much information as possible*
Liver Disease			
Kidney Disease			
Diabetes / Family history of diabetes			
Epilepsy			
Acid Reflux or Eating Disorder			
Hiatus Hernis			
Bone or Joint Disease			
Articial Joint			
Fainting Attacks or Blackouts			
Giddiness			
Any past Serious Illness or Infectious Disease			
Cancer / Radiotherapy			
Depressive Illness			
Stroke			
Nervous Problems			
Tuberculosis			
Severe Headaches			
Cold Sores			

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MEDICATIONS	*Please provide name and doses for all prescribed medicines, tablets, ointments, injections or inhalers (inc. contraceptives and HRT) that you are taking*

DOCTOR	*Please provide your doctors name, address and contact telephone number*

EMERGENCY CONTACT	*Please provide details of your emergency contact*
Name of contact	
Relationship	
Telephone number	
Contact address	

PRINT NAME	SIGNATURE	DATE