Medical History

Full Name:

Date of Birth:

Doctors Practice:

Certain medical conditions, and medicines used to treat them, can affect your dental treatment.
To ensure that you receive the best and most appropriate treatment, please complete the following questionnaire which will be treated in **the strictest confidence**. Please feel free to discuss these issues in private with your dentist. ***Please ensure this form is filled out accurately & completely as failure to disclose any information could result in serious health risks.***

Do you suffer from or have you ever suffered from any of the following:	Yes	No		Yes	No
Rheumatic Fever			Bruising or excessive bleeding		
Any heart complaint, heart surgery or stroke			Anaemia		
Diabetes (or is there a family history)			High blood pressure		
Tuberculosis			Kidney problems or disease		
Epilepsy or fainting attacks			Liver disease (e.g., jaundice or hepatitis)		
Chronic Bronchitis or Asthma			Cold sores		
Bone or joint disease (eg Osteoporosis)			HIV / AIDS		
Did you receive growth hormone treatment before the mid 1980's			Blood refused by the blood transfusion service		
Do you have any close relatives with Creutzfeldt Jakob Disease			Any other serious illness or infectious disease		

Please answer the following questions:	Yes	No	Comments
Do you consider yourself to be generally fit and healthy?			
Are you currently on any medication or do you anticipate being so in the near future (e.g., tablets, ointments, injection or inhalers including contraceptives or HRT)? If yes, please give details.			
Have you been treated recently with hydrocortisone or corticosteroids?			
Have you been under a Doctor's care or hospitalised in the last year?			
Are you attending or waiting to attend a doctor, specialist or hospital as an in-patient or an out-patient? If yes, please give details.			
Have you ever had surgery as an in-patient? If yes, please give details.			
Have you ever had a joint replacement operation?			
Have you ever been in contact with any viruses, e.g. Hepatitis B or HIV?			
Have you ever had an adverse reaction to a local or general anaesthetic or any dental procedure? If yes, please give details.			
Have you ever experienced hives, asthma or hayfever like symptoms as a result of coming into contact with latex gloves?			
Are you allergic to any medicines (e.g. antibiotics) or substances or foods?			
Do you bleed easily when cut or does the bleeding take a long time to stop?			
Is there any further information you feel may be relevant?			
Female patients only: Is there a possibility you may be pregnant?			
Do you carry a medical warning card?			
Do you smoke? If yes, how many per day?			
Do you chew tobacco, pan, use gutkha or supari now or in the past?			
How many units of alcohol do you consume per week on average?			

Signature: **Date:**