

Medical History Form

Surname (Mr/Mrs/Miss/Ms) _____

Doctor's Name and Address _____

Forename _____

Address _____

Postcode _____

Tel. No. (Home) _____ Tel. No. (Work) _____

Date of Birth _____ Occupation _____

Certain medical conditions can affect dental treatment and vice versa. Please complete this form by ticking the appropriate boxes and answering the questions

All details will be strictly confidential

Rheumatic fever Yes No

Any heart complaint, heart surgery or stroke Yes No

Diabetes Yes No

Epilepsy or fainting attacks Yes No

Chronic bronchitis or asthma Yes No

Hepatitis Yes No

Excessive bleeding Yes No

High blood pressure Yes No

Any other serious illness Yes No

Do you carry a medical warning card Yes No

Are you allergic to any medicine, tablets or substances Yes No

Are you at present taking any medicine or tablets Yes No

Are you pregnant Yes No

In the past 2 years have you

undergone any operations Yes No

been treated with hydro-cortisone or corticosteroids Yes No

Other details

Have you ever had a joint replacement operation Yes No

Do you have a close relative who has or has had CJD Yes No

Were you treat with growth hormone before the mid 1980s Yes No

Have you ever had brain surgery Yes No

Are you HIV positive Yes No

What is your average weekly consumption of alcohol _____

If you smoke, what is your average weekly consumption _____

Additional Notes _____

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

Patient's signature _____

Date _____