

Certain medical conditions can affect dental treatment and vice versa. Like all dental practices, we ask patients for information about their general health to help us treat them safely. Please write your contact details below, answer the health questions and then sign the form on the reverse where indicated. We will show you the form at later visits so that you can tell us whether there has been any change in your general health.

## All details will be strictly confidential

SURNAME:	<input type="text"/>	TITLE:	<input type="text"/>
FORENAME(S):	<input type="text"/>		
ADDRESS:	<input type="text"/>		
	<input type="text"/>	POSTCODE:	<input type="text"/>
TEL NO. HOME:	<input type="text"/>	WORK:	<input type="text"/>
		MOB:	<input type="text"/>
EMAIL ADDRESS:	<input type="text"/>	DATE OF BIRTH:	<input type="text"/>
OCCUPATION:	<input type="text"/>		
DATE OF LAST DENTAL TREATMENT:	<input type="text"/>		
DOCTOR'S NAME:	<input type="text"/>		
DOCTOR'S ADDRESS:	<input type="text"/>		
	<input type="text"/>		
DOCTOR'S TEL NO:	<input type="text"/>		

Do you have, or have you ever suffered from:	YES	NO	GIVE DETAILS
Rheumatic Fever?	<input type="text"/>	<input type="text"/>	<input type="text"/>
Heart complaints/problems, Angina, Stroke? (including heart murmur and surgery)	<input type="text"/>	<input type="text"/>	<input type="text"/>
High blood pressure?	<input type="text"/>	<input type="text"/>	<input type="text"/>
Diabetes or does anyone in your family?	<input type="text"/>	<input type="text"/>	<input type="text"/>
Fainting attacks, giddiness, blackouts or Epilepsy?	<input type="text"/>	<input type="text"/>	<input type="text"/>
Chronic Bronchitis, Asthma or other chest conditions?	<input type="text"/>	<input type="text"/>	<input type="text"/>
Arthritis?	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hay Fever or Eczema?	<input type="text"/>	<input type="text"/>	<input type="text"/>
Bruising or persistent excessive bleeding following injury, tooth extraction or surgery?	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hepatitis or liver disease (e.g. Jaundice)?	<input type="text"/>	<input type="text"/>	<input type="text"/>
Allergies to any medicines, tablets (e.g. Antibiotics), substances (e.g. latex/rubber) or foods?	<input type="text"/>	<input type="text"/>	<input type="text"/>
Any other serious illness?	<input type="text"/>	<input type="text"/>	<input type="text"/>

	YES	NO	GIVE DETAILS
Do you smoke tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<b>Are you currently:</b>			
Pregnant (Female)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers, including contraceptives)?	<input type="checkbox"/>	<input type="checkbox"/>	IF YES LIST IN ADDITIONAL NOTES BELOW
Receiving treatment from a doctor, hospital or clinic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Carrying a warning card?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

**In the past 2 years:**

Have you undergone any operations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Have you been treated with steroids?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Have you ever had a joint replacement operation? (or other implant)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Would you like to speak to the dentist privately about any problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Please tell the dentist if you are HIV positive

Please use this space below to give any other details which your dentist might need to know about, such as self-prescribed medicines (e.g. Aspirin). If you are not sure of any of the questions or if your medical circumstances change, please inform the dentist.

COMPLETED BY (Please tick)    SELF:     PARENT:     GUARDIAN:

SIGNATURE:     DATE:

**MEDICAL HISTORY UPDATE:**

Please check that the health information on this form is still correct. If not, amend as necessary or note any changes below:

DATE	NO CHANGE	LIST ANY CHANGES BELOW	PATIENTS INITIALS

**ADDITIONAL NOTES:**

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