

## 854 Dental Health : Confidential Medical History

In order to provide the best and safest treatment, your dentist needs to know of any problems which may affect your treatment. Please complete as fully as possible.

Title: \_\_\_\_\_ Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_

PostCode: \_\_\_\_\_ DaytimeTel No: \_\_\_\_\_

Mobile: \_\_\_\_\_ Emergency Contact Name/No: \_\_\_\_\_

Occupation: \_\_\_\_\_ GP's Name & Address \_\_\_\_\_

	Yes	No	If yes please give details below
Are you attending or receiving treatment from a doctor, hospital clinic or specialist?			
Are you taking any medicines, tablets, drugs or injections or using any creams, ointment or inhalers?			*See Overleaf
Are you taking or have you taken steroids in the last 2 years?			
Are you allergic to penicillin?			
Are you allergic to any medicines, foods, or materials?			
Are you pregnant or a nursing mother?			
Are you HIV positive?			
Have you had jaundice, liver or kidney disease or hepatitis?			
Have you had rheumatic fever or chorea (St Vitis Dance)?			
Have you been told that you have heart problems, angina, or high blood pressure, a heart murmur or had a heart attack?			
Have you ever had your blood refused by the blood transfusion service?			
Have you ever had a bad reaction to a local or general anaesthetic?			
Have you had joint replacement or other implant surgery?			
Have you ever been hospitalised for any reason?			
Do you have arthritis?			
Do you have a pacemaker or have you had heart surgery?			
Do you suffer from hay fever, eczema or any other allergy?			
Do you suffer from bronchitis, asthma or any other chest conditions?			
Do you have fainting attacks, giddiness, blackouts / epilepsy?			
Do you have diabetes or does anyone in your family?			
Do you bruise easily or suffer persistent bleeding following an extraction, surgery or injury or does anyone in your family?			
Do you have any history of radiotherapy, especially to the head and neck region?			
Do you ever suffer from cold sores?			
Do you carry a warning card/medical alert card			

**Please continue overleaf and sign both sides please.....**

Date: \_\_\_\_\_ Signature : \_\_\_\_\_

