Surname (Mr/Mrs/Miss/Ms)_____
Forename_____
Address_____
_____Postcode_____
Tel. no.(Home)_____Tel. no.(Business)_____
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.

Questions	yes	no
Are you currently receiving treatment from a doctor, hospital or clinic.		
Are you currently taking any prescribed medicines (eg. tablets, ointments or inhalers. including contraceptives and hormone therapy treatment.)		
Are you carrying a medical warning card		
Do you suffer allergies to any medicines (eg. Penicillin), substances (eg. Latex) or foods		
Do you suffer from Hay Fever or eczema		
Do you suffer from Bronchitis, Asthma or other chest conditions		
Do you suffer from fainting attacks, giddiness, blackouts or epilepsy		
Do you suffer from heart problems, angina, blood pressure problems or stroke		
Are you diabetic (or is anyone in your family)		
Do you suffer from Arthritis		
Do you suffer from bruising or persistent bleeding following injury, tooth extraction or surgery.		
Do you suffer from any infectious diseases (including HIV or Hepatitis)		
Have you ever had Rheumatic fever or Chorea		
Have you ever had liver disease (eg. Jaundice, hepatitis) or kidney disease		
Have you ever had any other serious illness		
Have you ever had blood refused by the blood transfusion services		
Have you ever had a bad reaction to general or local anaesthetic		
Have you ever had joint replacement or other implant		
Have you ever had treatment that required you to be in hospital		
Have you ever had heart surgery		
Have you ever had brain surgery		
Did you receive growth hormone treatment before the mid 1980s		
Do you have any close relatives (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob disease (mad cow disease)		
Do you regularly drink more than 21 units of alcohol a week		
Do you smoke any tobacco products now (or did you in the past)		
Do you chew tobacco, pan, use gutka or supari (or did you in the past)		
Is there any other information which your dentist might need to know about, such as self-prescribed medicines		

Name and address of doctor

Notes To include medication

Signature date