

Medical History

In common with all dentists, we ask you for information about your general health to help us treat you safely.

All details will be kept STRICTLY CONFIDENTIAL

You will be asked to complete one of these forms every six months to help us maintain up-to-date records

Name	Date of Birth
Address	N.I. Number
☎ Home	☎ Mobile
Doctor	Email
Emergency Contact Name	Occupation
How would you prefer to be contacted for your Check-Up Reminder?	>> ☎
<input type="checkbox"/> Email <input type="checkbox"/> Text Message <input type="checkbox"/> Letter	
<i>For New Patients:</i> Source of referral: <input type="checkbox"/> Street Sign <input type="checkbox"/> Family <input type="checkbox"/> Website <input type="checkbox"/> Yell.com <input type="checkbox"/> Emergency <input type="checkbox"/> Other _____	
Amendments	

Do you have or have you had any of the following?




Please circle

- Y / N Rheumatic Fever
- Y / N Heart Problems/ Angina/ Stroke
- Y / N Pacemaker/ Heart Surgery
- Y / N High/ Low Blood Pressure *(Please delete)*
- Y / N Chronic Bronchitis/ Asthma/ Emphysema/ COPD
- Y / N Diabetes
- Y / N Epilepsy/ Fainting/ Blackouts
- Y / N Liver Disease/ Hepatitis or Kidney Disease
- Y / N Excessive bleeding/ Blood disorder
- Y / N Anxiety
- Y / N HIV or AIDS
- Y / N Cancer
- Y / N Joint Replacement/ Implant _____
- Y / N Any other serious illness/ Operation _____

Are you

- Y / N Taking medication/ tablets *incl. Alendronic Acid*
- If medication unchanged tick here
- Y / N Allergic Penicillin/Amoxicillin Latex Other _____

Do You or Are You any of the following?

- Y / N Smoke If 'Y' Number per day? _____
- In the past, Number per day? _____
- Y / N Drink Alcohol If 'Y' On average units/week _____
- (1unit = ½ pint of beer / small wine / 1shot of spirit)
- Y / N Use Manual Electric Toothbrush
- 


- Y / N Use
- Y / N Have a high acid intake?
- (Carbonated (fizzy) drinks, fruit juices, or citric fruits)*
- Eat Sugary Food *(Chocolate, Biscuits, and Cake etc.)*
- 0-1/day 2-4/day 5+/day
- Y / N Over 24 stones in weight

For Women

- Y / N Pregnant/ likely to be pregnant - Due Date _____
- Y / N Nursing Mother
- Y / N Taking Oral Contraceptives

Medication / Notes: *(Please list overleaf if necessary)*

Form completed by: Self Parent Guardian Staff _____

I understand the above information and agree this form was completed correctly to the best of my knowledge.

Patient Signature _____ Date ____/____/____ Dentist Sign _____