TYRONE HOUSE
DENTAL SURGERY

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 Email

Doctor Occupation

Emergency Contact Name >> ☎

How would you prefer to be contacted for your Check-Up Reminder? ☐ Email ☐ Text Message ☐ Letter

For New Patients: Source of referral: ☐ Street Sign ☐ Family ☐ Website ☐ Yell.com ☐ Emergency ☐ 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?

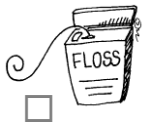
Y / N Smoke If 'Y' Number per day? _____

In the past, Number per day? _____

Y / N Drink Alcohol If 'Y' On average units/week _____

(1unit = ½pint 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 _____