

# Medical History



Name.....Date of Birth.....

Address.....  
..... Postcode.....

Contact telephone number..... Occupation .....

Are you a smoker Yes/No - If yes, how many per day.....

Are you interested in quitting? Yes/ No

Weekly alcohol consumption in units..... (175ml wine = 2units, Pint of beer =3units)

Are you pregnant Yes/No – If yes, what is your due date? .....

Please answer the following questions accurately by circling yes or no

Do you have?

Rheumatic fever or choera Yes/No

Chronic bronchitis, asthma or any respiratory disease Yes/No

Epilepsy, blackouts or fainting Yes/No

Hepatitis, jaundice, liver or kidney disease Yes/No

Excessive bleeding/bleeding disorders Yes/No

High blood pressure or angina Yes/No

Heart disease/pace maker or any heart conditions Yes/No

Arthritis Yes/No

Joint replacement Yes/No

Steroid therapy in the past 2 Years Yes/No

Herpes/cold Sores Yes/No

HIV positive/hepatitis A/B/C Yes/No

Serious illness or medical conditions Yes/No

Allergies to medicines/tablets other materials Yes/No

Diabetes Yes/No

Any reaction to local anaesthetic Yes/No

Details.....

Medications - please list .....

Name & Address of GP .....

Next of Kin contact details below

Name/relationship to you .....

Contact details - Mobile..... Home.....

Patient Signature.....Dentist Signature.....

## UPDATES

Date..... Changes Yes/No..... Signed.....

Date..... Changes Yes/No..... Signed.....

Date..... Changes Yes/No..... Signed.....