Medical History Form

To obtain the best and safest treatment, your dentist needs to be aware on any medical problems which may affect your treatment. All information disclosed is confidential and is not disclosed to any other parties.

Woburn Sands DENTAL PRACTICE

Title:	First Name:	Last Name:
Sex: Male/Female	Date Of Birth:	Occupation:
Home Address:		
Postcode:	Home Tel No:	Mobile:

Doctor's Name and Address:	Doctor's Tel No:
Name Of Parent/Carer (If Child):	Name Of School:

Are You/Have You:	**Yes:**	**No:**	**Details:**
1. Attending or receiving treatment from a Doctor, Hospital or Clinic?			
2. Taking any prescribed medicines (such as tablets, ointments, injections or inhalers including contraceptives or hormone replacement therapy?			
3. Taking steroids or have you taken them in the last 2 years?			
4. Allergic to any medicines (eg antibiotics), substances such as latex or rubber, or any foods?			
5. Carrying a warning card?			
6. Pregnant? (If yes please enter due date)			
7. Had Rheumatic Fever or Chorea (St Vitus Dance)?			
8. Had Jaundice, Kidney Disease or Hepatitis?			
9. Ever been told that you have a Heart murmur or had any Heart problems, Angina or High Blood Pressure?			
10. Had a Heart attack or any form of Heart surgery (eg a Pacemaker)?			
11. Had Brain surgery or Growth Hormones before the mid-80s?			
12. Any history of family illness, for example Sickle Cell Anaemia, Thalassemia or CJD Disease?			
13. Suffering from any infectious diseases including HIV, Hepatitis B or Tuberculosis (TB)?			

Are You/Have You:	Yes:	No:	Details:
14. Had a blood test or inoculation recently?			
15. Had a bad reaction to a local or general anaesthetic?			
16. Had a joint replacement or any other implants?			
17. Been hospitalised? If yes why an when?			

Do you suffer from:	Yes:	No:	Details:
1. Arthritis?			
2. Hayfever, Eczema or Cold Sores?			
3. Bronchitis, Asthma or any other chest condition?			
4. Fainting attacks, giddiness, blackouts or Epilepsy?			
5. Diabetes, or do you have a family history of diabetes?			
6. Bruising or persistent bleeding following injury, tooth extraction, surgery, or do you have a family history of bleeding disorders?			
7. Any other serious illness?			
Details of any treatment from your doctor, hospital/clinic or specialist:			

Lifestyle questions:	Yes:	No:	Details:
1. Do you drink alcohol? If yes, how many units do you drink per week? (1 unit is ½ pint of lager, single measure of spirits, or 1 glass of wine)			Number of units?
2. Do you smoke or use any tobacco products now or in the past?			How many per day?
3. Please give any other details your dentist might need to be made aware of such as any self-prescribed medication or recreational drugs?			Please use space below
Details of prescribed/self-prescribed medication or recreational drugs used:			

Date:	Patient Signature:	Checked By: