

Medical History

Surname: _____ Forename(s): _____

Address: _____

Postcode: _____

Tel No: _____ Mobile No: _____

D.O.B: _____ Occupation: _____

Do you have or have you ever suffered from?

Rheumatic Fever

Any heart complaint, heart surgery or stroke

Diabetes

Epilepsy or fainting attack

Chronic bronchitis or asthma

Hepatitis

Excessive bleeding

High blood pressure

Do you carry a medical warning card

Are you allergic to any medicine, tablets or substances (list below)

Are you at present taking any medicines or tablets (list below)

Are you pregnant?

In the past two years have you undergone any operations?

Have you been treated with hydro-cortisone or corticosteroids?

Have you ever had a joint replacement operation?

Do you have a close relative who has or has had CJD?

Did you receive growth hormone treatment before the mid 1980s?

Have you ever had brain surgery?

Are you HIV positive?

Any other serious illness _____

What is your average weekly consumption of alcohol? _____

If you smoke, what is your average per week? _____

If you have ticked any questions above, please give details:

Name and address of your doctor:

If you are not sure of any of the questions or if your medical circumstances change please inform the Dental Surgeon.

Patients signature: _____

Date: _____