PLEASE TAKE A MOMENT TO FILL OUT OUR MEDICAL HISTORY FORM

Surname:________________________ Forename:________________________
Address:____
Post Code:________________________ Email:________________________
Telephone No.:____________________ Mobile No:____________________
Date of Birth:____________________ Occupation:____________________

All information given will be strictly confidential.
Do you have or have you ever suffered from: (Tick any that apply)

- ☐ Rheumatic Fever
- ☐ Epilepsy or Fainting attacks
- ☐ Chronic Bronchitis or Asthma
- ☐ High Blood Pressure
- ☐ Acid Reflux or Eating Disorder
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Excessive Bleeding
- ☐ Heart Surgery or Stroke
- ☐ Bone or Joint Disease

Any other Serious Illnesses? ____
Do you carry a Medical Warning Card? ____________________________________
Are you allergic to any medicine, tablets, substances or latex? ____________________
____
Are you at present taking any medications or tablets? ______________________
____
In the past 2 years, have you undergone any operations? ____________________
____
Have you been treated with hydro-cortisone or corticosteroids? ________________
____
Have you ever had a joint replacement operation? __________________________
____

☐ Please tick if you are HIV positive.
What is your average weekly consumption of alcohol? ________________________
If you smoke, what is your average per day? ______________________________
Do you use any recreational drugs? ______________________________________
____
Anything else your dentist should know? __________________________________

Name of your Doctor: ____
Address of your Doctor: ____

Patients Signature: ______________________________ Date: ______________________

If you are unsure of any of the questions, please inform the Dentist.

☐ Tick here if you would not like us to send you future appointment reminders, updates and offers via email.