

Patient Personal Details

Title	Permanent Address
Surname	
Forename	
Date of birth: ____/____/____	

Medical History cont.

Please tick appropriate box. If you have further details, including any allergies or pills, tablets or other medication that you take, **please enter them in the 'Further Details' box.**

	Yes	No	Unsure
Are you aware of anything that you are allergic to? (penicillin or another antibiotic, pollen, latex, food, jewellery or any other substance)			
Have you ever had any heart problems/conditions? (blood pressure problems, angina or chest pains, pacemaker or any other heart or blood vessel condition)			
Have you ever had any chest or breathing problems/conditions? (asthma, bronchitis or any other breathing problems)			
Have you ever had any stomach, gut, liver or kidney problems/conditions?			
Do you have any blood or bleeding problems/conditions?			
Are you prone to fits/faints or do you have epilepsy?			
Do you have any problems or conditions relating to your bones, joints or muscles? (arthritis, muscle weakness or any other condition)			
Do you have hepatitis, HIV, AIDS or tuberculosis (TB)?			
Are you pregnant or is there a possibility you could be pregnant?			
Do you have diabetes?			
Do you have a medical condition or problem not specified above?			
Are you currently under treatment from a doctor, consultant or clinic?			
Do you carry a medical warning card?			
Are you taking or meant to take medicine prescribed by your doctor or otherwise? (Tablets, pills, patches, medicines, inhalers, ointments, injections, oral contraceptives, herbal remedies, recreational drugs, recent vaccinations). If yes, please enter them in the 'Further Details' box.			
Are there any conditions that run in your family? (Diabetes, sickle cell disease or any other conditions). If yes, please enter them in the 'Further Details' box.			
Have you ever had an illness or operation that required hospital treatment? If yes, please enter them in the 'Further Details' box.			

Further Details including any allergies or pills, tablets or other medication that you take

Smoking status

I have never smoked

I am an ex-smoker Number of years an ex-smoker _____

I am a smoker Number of cigarettes etc smoked per day _____

Alcohol consumption

1 unit of alcohol = Half a standard 175ml glass of wine (12.5% abv)
 Half a pint normal strength
 beer, lager or cider (4% abv)
 One 25ml measure of spirits (40% abv)

On average how many units
do you drink in a week? _____ units

What is the largest number of
units you drank in a single day
in the last week? _____ units

Date	Changes	Signature of patient, parent or carer

After you have completed this form please sign it and return it to a member of the Dental Team.

Signature of Patient, Parent or Carer

Date