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**MEDICAL HISTORY**

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| **TITLE** | | **FIRST NAME: SURNAME: DATE OF BIRTH : / /** |
| **ADDRESS** | | **POSTCODE:** |
| **MOBILE NO** | | **HOME NO:** |
| **EMERGENCY**  **CONTACT** | | **PHONE NO: RELATIONSHIP:** |
| **GP DETAILS** | | **HEALTH AND CARE NUMBER:** |
| **EMAIL** |  | |

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| **1- Have you taken any medicine tablets, capsules, or drugs during the past two years?** | Y  N |
| **PLEASE LIST ALL MEDICATION:** | |
| **2 - Have you experienced any allergies or unusual effects from any tablets drugs injections or anaesthetic?** | Y  N |
| **DETAILS:** | |
| **3 - Are you receiving any medical treatment at the present time?** | Y  N |
| Details | |
| **4 - Have you been a patient in hospital during the past two years?** | Y  N |
| Details | |
| **5 - Are you, or have you been, under the care of a doctor during the past two years?** | Y  N |
| Reason | |
| **6 - Have you ever had any of the following? If yes, please tick as appropriate.** | |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | Rheumatic Fever |  | Hepatitis - Specify type: |  | Epilepsy |  | Cold Sores | |  | Heart Trouble |  | Bronchitis or Chest Problems |  | Anaemia |  | Asperger’s | |  | High Blood Pressure |  | Severe Headaches |  | Diabetes |  | A.D.H.D. | |  | Asthma |  | Drug Dependence |  | Kidney Trouble |  | Autism | |  | Arthritis |  | Depressive Illness |  | Gastric Problems |  |  | | |
| **7 - Have you had any prosthetic surgery? (eg Heart Valve/Hip Replacement)** | Y  N |
| **8 - Pregnant?** | Y  N |
| If so, how many months: | |
| **9 - Are you taking or have you taken any Bisphosphonates (Osteoporosis)** | Y  N |
| **10 - Are you HIV positive? (if yes please give dentist details)** | Y  N |
| **11 - Are you at risk of HIV exposure?** **(if yes please give dentist details)** | Y  N |
| **12 - Have you CJD or VCJD? (if yes please give dentist details)** | Y  N |
| **13 - Are you at risk of CJD or VCJD? (if yes please give dentist details)** | Y  N |
| **14 - Do you smoke?** | Y  N |
| Average per day: | |
| **15 - Have you ever experienced excessive bleeding or bruising from dental treatment, cuts, or scratches?** | Y  N |
|  | Y  N |

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| --- | --- |
| SIGNED: | DATE: |