|  |  |
| --- | --- |
|  |  |

**MEDICAL HISTORY**

|  |  |
| --- | --- |
| **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** |   |

|  |  |
| --- | --- |
| **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[ ]  |

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