Surname (Mr/Mrs/Miss/Ms) .....

First Name .....

Address .....

.....

..... Post Code .....

Tel. No. (Home) ..... (Work) .....

Date of Birth ..... Occupation .....

MEDICAL HISTORY

Certain medical conditions can affect dental treatment and vice versa.

All information will be strictly confidential.

	YES	NO
Do you, or have you, ever suffered from:		
Rheumatic fever	.....	.....
Any heart complaint (including murmur)	.....	.....
Diabetes	.....	.....
Epilepsy	.....	.....
Chronic bronchitis or asthma	.....	.....
Hepatitis	.....	.....
Excessive bleeding	.....	.....
High blood pressure	.....	.....
Any other serious illness	.....	.....
Are you:		
Allergic to **any** medicine or tablets	.....	.....
At present taking any medicine or tablets	.....	.....
Pregnant	.....	.....
The mother of a child under 12 months old	.....	.....
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	.....	.....
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	.....	.....
Please tick **or tell the dentist** if you are HIV positive	.....	.....

Name and address of your doctor:

.....

.....

.....

PATIENT'S SIGNATURE..... Date .....