THIS DOCUMENT IS AVAILABLE IN LARGER PRINT
TITCHFIELD DENTAL CLINIC

MEDICAL HISTORY FORM

TITLE:	FIRST NAME:	SURNAME:
DOB:		
ADDRESS:		
HOME TEL NO:	MOBILE:	WORK:
E-MAIL:		
DOCTORS NAME & ADDRESS:		
HOW LONG SINCE YOUR LAST DENTAL VISIT?		

ARE YOU?	YES	NO
Attending or receiving treatment from any doctor? (please give reasons)		
Taking any medicines or tablets? If so please list overleaf.		
Taking or have taken steroids in the last two years?		
Allergic to any medicines, food or materials (please list)?		
Likely to be pregnant?		

HAVE YOU?	YES	NO
Ever had jaundice, liver or kidney disease or hepatitis?		
Ever had rheumatic fever or been told you have a heart murmur?		
Ever been told you have a heart problem or had a heart attack?		
Ever had infective endocarditis or heart valve replacement or any form of heart surgery?		
High or low blood pressure? (please circle)		
Had a blood test recently?		
Ever had a bad reaction to a local or general anaesthetic?		
Ever had a stroke?		
Ever had a major operation or recently received hospital treatment? (please detail)		
Ever had your blood refused by the blood transfusion service?		
Ever been diagnosed or suspected as having CJD or HIV positive?		

DO YOU?	YES	NO
Have a pacemaker?		
Suffer from bronchitis or asthma?		
Bruise easily or bleed excessively?		
Have fainting attacks, giddiness or epilepsy?		
Have diabetes?		
Carry a warning card?		
Drink alcohol? If so how many units a week?		
Smoke? If so how many a day?		
Know that smokers lose four times as many teeth through gum disease as non-smokers do?		
Know that smoking and drinking alcohol significantly increase your risk of mouth cancer?		
Do you become anxious or uncomfortable when receiving dental treatment?		

THIS DOCUMENT IS AVAILABLE IN LARGER PRINT
TITCHFIELD DENTAL CLINIC

NAME OF MEDICATION	REASON FOR TAKING	TODAYS DATE

PLEASE INDICATE HOW YOU HEARD ABOUT US

ONE STOP LOCAL		FAMILY/FRIEND		STREET SIGN	
CHAD NEWSPAPER		WEBSITE/INTERNET		OTHER	

I declare that I have completed this medical history form to the best of my knowledge.

SIGNATURE: **DATE:**

PATIENT/PARENT/GUARDIAN

YOUR MEDICAL FORM NEEDS TO BE UPDATED EVERY 6 MONTHS- PLEASE CHECK YOUR DETAILS AND SIGN BELOW. (PLEASE MAKE ANY AMENDMENTS).

SIGNATURE	DATE OF UPDATE	SIGNATURE	DATE OF UPDATE

Please give us your next of kin name and contact details. In case we needed to contact them in an emergency	