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| **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? | | | | | | | | | | | |  |  |
|  | | | | | | | | | | | | | |
| **NAME OF MEDICATION** | | | **REASON FOR TAKING** | | | | | | | **TODAYS DATE** | | |  |
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| **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** | | | |  |
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| Please give us your next of kin name and contact details. In case we needed to contact them in an emergency | |  | | | | | | | | | | |  |
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