**Medical History Form** **(Please complete by ticking the appropriate boxes. All details will be strictly confidential)**

Title: Date of Birth

Forename: Surname:

Address: Tel no (day) (evening)

Mobile no Email

Postcode: Occupation

**Are you currently:**

- ☐ receiving treatment from a doctor, hospital or clinic
- ☐ taking any prescribed medicines (e.g. tablets, ointments or inhalers, including contraceptives and H.R.T (Please list in box below)
- ☐ carrying a medical warning card
- ☐ pregnant

Current medications

**Do you have or have you ever had:**

- ☐ allergies to any medicines (e.g. penicillin), substances (e.g. latex, rubber) or foods
- ☐ hayfever or eczema
- ☐ bronchitis, asthma or other chest conditions
- ☐ fainting attacks, giddiness, blackouts or epilepsy
- ☐ heart problems, angina, blood pressure problems or have you ever had a stroke
- ☐ diabetes (or does anyone in your family)
- ☐ arthritis
- ☐ bruising or persistent bleeding following injury, tooth extraction or surgery
- ☐ infectious diseases (including HIV or hepatitis)
- ☐ rheumatic fever or chorea
- ☐ liver disease (e.g. jaundice, hepatitis) or kidney disease
- ☐ any other serious illness
- ☐ blood refused from the blood transfusion service
- ☐ a bad reaction to local or general anaesthetic
- ☐ a joint replacement or other implant
- ☐ any serious surgery
- ☐ growth hormone treatment before the mid 1980's
- ☐ any close relatives (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob disease

**Do you:**

- ☐ regularly drink more than 21 units of alcohol per week
- ☐ smoke any tobacco products (or did you in the past)
- ☐ chew tobacco, pan use gutkha or supari (or did you in the past)
- ☐ is there any other information which your dentist might need to know about , such as self-prescribed medicines (e.g. aspirin)

**G.P. Practice** **Signature** **Date**