Name *Date of Birth*

Medical History

Certain medical conditions can affect dental treatment and vice-versa.
Please complete this form by ticking the appropriate boxes and answering the questions.

All details will be strictly confidential

Do you have or have you ever suffered from:

Any heart complaint / heart surgery / stroke / pacemaker fitted?		YES / NO
Rheumatic fever?		YES / NO
High Blood Pressure?		YES / NO
Diabetes?		YES / NO
Excessive bleeding / bruising?		YES / NO
Chronic bronchitis /asthma / emphysema?		YES / NO
Epilepsy or fainting attacks?		YES / NO
Hepatitis / liver disease / jaundice / kidney disease?		YES / NO
Any other serious illness?		YES / NO
Do you carry a MEDICAL WARNING ALERT CARD?		YES / NO
Are you ALLERGIC to any FOODS,MEDICINES,SUBSTANCES OR LATEX?	*List below*	YES / NO
At present taking any medicine or tablets?	*List below*	YES / NO
Pregnant?		YES / NO
In the past two years have you undergone any operations?		YES / NO
Or been treated with Hydrocortisone or corticosteroids?		YES / NO
Have you ever had a joint replacement operation / organ transplant?		YES / NO
Is there any chance you may have contracted HIV, hepatitis, CJD?		YES / NO
Do you chew Tobacco, Betal nut, Gutkha, Paan or Sopari		YES / NO
If you smoke, what is your average per week?		.....
If you drink what is your average weekly consumption of alcohol?		.....

If 'yes' to any questions, please supply details in 'Notes' below. Include medication.

Name and Address of your Doctor?

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If you are not sure of any of the questions, or if your medical circumstances change, please let us know

Patient's Signature:..... Date:.....

Updated: ....

Thank you

"Dedicated to provide the best treatment possible in a friendly and caring environment"