welcome

Surname (Mr/Mrs/Miss/Ms) ....
Forename..
Address..
MOB:- ....Postcode..
Tel no. (home)..Tel no. (business) ....
Date of Birth..Occupation ....

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:

	yes	no
Rheumatic fever?	☐	☐
Any heart complaint (including heart 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? (list below in notes)	☐	☐
at present taking any medicine or tablets? (list below in notes)	☐	☐
pregnant?	☐	☐
the mother of a child under 12 months?	☐	☐
In the past 2 years have you undergone any operations?	☐	☐
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-1980's?	☐	☐
Have you ever had brain surgery?	☐	☐
Please tick or **tell the dentist** if you are HIV positive	☐	☐

What is your average weekly consumption of alcohol? ....
If you smoke, what is your average per week? ....

If 'yes' to any questions please supply details in 'Notes' below or use back of form

Name and address of your doctor:
....
....
....
....

Notes: NHS NUMBER:-
....
National insurance No.
....

If you are not sure of any of the questions, or if your medical circumstances change, please inform the Dental Surgeon

Patients signature: .... **Date**..

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