

Excellence in dental care

Title _____ Surname _____ First name _____

Date of Birth _____ Sex: Male/Female _____

Address _____

Tel.number:Home. _____ Work. _____ Mobile _____

Occupation. _____

Your Doctor's name and address. _____

How long since you last visited a Dentist? _____

Are You?

Yes No

Details

Attending or receiving treatment from any doctor?			
Taking any medicines or tablets from your doctor?			
Taking or have you taken any steroids in the last two years?			
Allergic to any medicines, foods or materials?			
Likely to be pregnant?			

Have You?

Ever had jaundice, liver or kidney disease, or hepatitis?			
Ever had rheumatic fever or been told that you have a heart murmur?			
Ever been told that you have a heart problem or had a heart attack?			
Ever had infective endocarditis, or a heart valve replaced or any form of heart surgery?			
High or low blood pressure?			
Had any blood tests 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?			
Ever had your blood refused by the Blood Transfusion Service?			
Ever been diagnosed or suspected as having V CJD or being HIV positive			

Do You?

Have a pacemaker?			
Suffer from bronchitis or asthma?			
Bruise easily or have you ever bled excessively?			
Have fainting attacks, giddiness or epilepsy?			
Have diabetes?			
Carry a warning card?			
Smoke and if yes how many a day?			
Drink alcohol and if yes how many units a week?			

Are there any other aspects of your health that you feel we should know about? _____

Signed: _____

Date: _____