west byfleet
DENTAL & IMPLANT CENTRE

MEDICAL HISTORY FORM

Please use BLOCK CAPITALS

Title	Full Name			
Date of Birth	Occupation			
Address Postcode:	Telephone Numbers Home: Work: Mob:	**Next Of Kin** Name: Phone:		
Email:	How did you find out about us?	Website	Local Paper	Friend/ Family
Your GP's details	Are you claiming an exemption for payment of dental charges			

Please tick as appropriate and give relevant details	Yes/ No	Details
Are you currently pregnant?		
Are you currently receiving treatment from a doctor, hospital or clinic?		
Have you ever had treatment that required you to stay in hospital?		
Do vou carry a medical warning card or Bracelet?		
Are you currently taking any prescribed medication (e.g., tablets, ointments or inhalers including contraceptives and hormone replacement therapy?		
Do you suffer from any allergies to medicines (e.g., penicillin), substances (e.g. latex or rubber) or foods?		
Do you suffer from Hay fever or eczema?		
Do you suffer from bronchitis, asthma or other chest conditions?		
Do you suffer from fainting attacks, giddiness. blackouts or epilepsy?		
Do you suffer from heart problems, angina, blood pressure problems or stroke?		
Are you diabetic (or is anyone in your family)?		
Do you suffer from arthritis?		
Do you suffer from bruising or persistent bleeding following injury, tooth extraction or surgery?		
Do you suffer from any infectious diseases (including HIV and hepatitis)?		
Have you ever had rheumatic fever or chorea?		
Have you ever had liver disease (e.g., jaundice, hepatitis) or kidney disease?		
Have vou (or anyone in your family) have/ had any type of cancer?		
Have vou ever had any other serious illness?		
Have you ever had blood refused by the Blood Transfusion Service?		
Have you ever had a bad reaction to general or local anaesthetic?		
Have you ever had brain surgery?		
Do you have any close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt iakob disease?		
If you are a female, do you regularly drink more than 14 units of alcohol ver week?		
If you are a male, do you regularly drink more than 21 units of alcohol per week?		
Do you or have you ever smoked any tobacco products? Please state how much and when.		
Is there any other information that your dentist might need to know about; such as self-prescribed medication (e.g. aspirin)?		
Do you suffer from Cold Sores?		
Have you ever had Heart Surgery, or been fitted with a Pacemaker?		
□ [Please tick the box if you do not wish to receive any e-mails regarding promotions, new services and practice news		
Signature		Date