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rf dental care

CONFIDENTIAL MEDICAL HISTORY

Mr/Mrs/Miss _____ Surname _____ First Name _____

Date of Birth _ _ / _ _ / _ _ _ _ NHS No. _ _ _ _ _ _ _ _ _ _ NI No. _ _ _ _ _ _ _ _ _

Address _____

City/Town _____ County _____ Post code __ __ __ __ __ __ __

Telephone No. Home (_ _ _ _ _) _ _ _ _ _ _ Work (_ _ _ _ _) _ _ _ _ _ _ Mobile (_ _ _ _ _) _ _ _ _ _ _

Doctor's Name & Address _____

ARE YOU ? Please circle YES or NO — MEDICATION / DETAILS

1. Likely to be pregnant ---------- YES / NO
2. Attending your doctor or hospital ---------- YES / NO
3. Taking any medication* (tablets/creams etc.) ---------- YES / NO

* **Please list medication in right column**.

4. Allergic to any drug or food (eg. penicillin) ---------- YES / NO
5. Do you smoke ? ---------- YES / NO
6. How many units of alcohol do you drink a week? --------- _ _ units.

HAVE YOU EVER HAD ?

7. Any heart problem / heart murmur ---------- YES / NO
8. High or low blood pressure ---------- YES / NO
9. Rheumatic fever ---------- YES / NO
10. Liver or Kidney problem(eg. hepatitis) ---------- YES / NO
11. Chest problems (asthma / bronchitis) ---------- YES / NO
12. Blood related diseases (leukaemia/anaemia/HIV) ------- YES / NO
13. Any problems with stopping bleeding ---------- YES / NO
14. A bad reaction to anaesthetic (local or general) ---------- YES / NO
15. Nervous problems ---------- YES / NO

DO YOU HAVE ?

16. A replacement heart valve ---------- YES / NO
17. Arthritis / Osteoporosis ---------- YES / NO
18. Diabetes ---------- YES / NO
19. Epilepsy ---------- YES / NO
20. To take steroids ---------- YES / NO
21. To carry a warning card ---------- YES / NO
22. Any other medical problems which your dentist should know about (serious surgery or illness in the past) - YES / NO

SIGNATURE _____ (patient / parent / guardian) DATE _ _ / _ _ / _ _ _ _

SIGNATURE _____ (patient / parent / guardian) DATE _ _ / _ _ / _ _ _ _