Your Medical History Form

whitemoss dental practice

Surname: **Tel. Home:**

Forename: **Tel. Work:**

Date of birth: **Mobile:**

Address:

Postcode:

E-Mail Address:

Please inform us of any changes at each visit	**NO (✓)**	**IF YES, PLEASE GIVE DETAILS**
Are you: Attending or receiving treatment or undergoing any investigations from a doctor, clinic or specialist?		
Taking medicines prescribed by your doctor (please list on reverse), and what are they for?		
Taking bisphosphonates/alendronic acid or have ever taken them? (This medication may be used for cancer patients or osteoporosis patients)		
Allergic to any medicines or materials? (inc. bleach or Penicillin)		
Have you had: Jaundice, liver or kidney disease?		
A Heart Murmur, Angina, High or Low Blood Pressure, Heart Disease or a Pacemaker?		
A bad reaction to local anaesthetic?		
HIV, HEP B, HEP C or cold sores?		
Steroids in the last 2 years?		
Depression or a mental illness?		
Do you: Have arthritis, if so what type and where?		
Suffer from bronchitis, asthma or other chest condition?		
Have fainting attacks, giddiness, blackouts?		
Have Epilepsy? If so, how long are the seizures?		
Have diabetes?		
Bruise easily or suffer prolonged bleeding or take a **blood thinning** medication?		
Carry a warning card?		
Smoke? (number per day)		
Drink alcohol? (number of units per week, approximately)		
Take recreational drugs?		
Have any other medical conditions? (please specify)		

P.T.O.

Are you currently:

Employed?

Pregnant?

Do you suffer from:

Migranes?

Snoring?

Receiving an NHS exemption which entitles you to FREE dental treatment? (see reception for more information).

MEDICATION?	WHAT FOR?

Please sign below:

PATIENT:	DENTIST:	DATE: