

Surname (Mr/Mrs/Miss/Ms) .....  
 Forename.....  
 Address .....  
 .....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? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Any heart complaint, heart surgery or stroke? .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy or fainting attacks? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic bronchitis or asthma? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive bleeding? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Any other serious illness? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you carry a medical warning card? .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you allergic to any medicine, tablets, substances or latex? (list below ) | <input type="checkbox"/> | <input type="checkbox"/> |
| at present taking any medicine or tablets? (list below in notes)..            | <input type="checkbox"/> | <input type="checkbox"/> |
| pregnant.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| In the past 2 years have you undergone any operations?.....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| been treated with hydro-cortisone or corticosteroids? .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a joint replacement operation? .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Please tick or tell the dentist if you are HIV positive.....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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: .....

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

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