Fairford Leys
SMILE CENTRE

Medical History

Failure to disclose all details may result in us being unable to treat you as it may put your health at risk or compromise your dental treatment.

Name_____DOB_____

Address_____

Postcode_____ Occupation _____ Home Telephone _____

Email Address_____ Mobile Number _____

Is it ok to leave a message regarding your dental appointments on it **Y/N**_____

Name and Address of GP_____

In the event of an emergency please contact:

Name _____ Mobile Number _____

DO YOU or HAVE YOU EVER HAD	YES	NO	PLEASE GIVE US DETAILS
Are you currently receiving treatment from a doctor, hospital or clinic?			
Are you currently taking any prescribed medicines (e.g. tablets, ointments or inhalers, including contraceptives and hormone replacement therapy)?			
Are you carrying a medical warning card?			
Do you suffer from allergies to any medicines (e.g. penicillin), substances (e.g. latex/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?			
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 disease (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 you ever had any other serious illness? E.g. Diabetes			
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 a joint replacement or other implant?			
Have you ever had treatment that required you to be in hospital?			
Have you ever had heart surgery?			
Have you ever had brain surgery?			
Did you receive growth hormone treatment before the mid 1980's?			
Do you have any close relatives (parent, sibling, child, grandparent or grandchild) with Creutzfeld-Jakob Disease?			
Do you regularly drink more than 14 units of alcohol per week?			
Do you smoke or chew any tobacco products now or did in the past?			
Are you pregnant?			Date due:

List all medication, impending surgery, or any other treatment you are currently receiving.

1._____ **2.**_____

3._____ **4.**_____

5._____ **6.**_____

Date: _____ **Signature:** _____

Dentist: _____

Medical History Update

Any Changes?

Yes/No _____ **Date**_____ **Signature**_____

Dentist_____

Yes/No _____ **Date**_____ **Signature**_____

Dentist_____

Yes/No _____ **Date**_____ **Signature**_____

Dentist_____

Yes/No _____ **Date**_____ **Signature**_____

Dentist_____

Yes/No _____ **Date**_____ **Signature**_____

Dentist_____

Yes/No _____ **Date**_____ **Signature**_____

Dentist_____