Firs Dental - Medical History

Surname [Mr,Mrs,Miss,Ms]: ______

Forename: ______ Date Of Birth: ______

Address: ______ Occupation: ______

______ Postcode: ______

E-mail: ______

Tel.Home: ______ Mobile: ______

Certain medical conditions can affect dental treatment and vice versa

Please complete this form by ticking the appropriate boxes and answering the questions with notes if needed, All details you give are strictly confidential. If you are not sure of any of these questions, please ask the Dentist

Do you have, or have you ever had?	**Yes**	**No**
Rheumatic fever	☐	☐
Heart complaints, heart surgery or stroke	☐	☐
Diabetes	☐	☐
Epilepsy or fainting attacks	☐	☐
Chronic Bronchitis or asthma	☐	☐
Hepatitis	☐	☐
HIV positive	☐	☐
Joint replacement	☐	☐
Treated with hydro-cortisone or corticosteroids	☐	☐
Excessive bleeding	☐	☐
High blood pressure	☐	☐
Operations in the past 2 years	☐	☐
Any other serious illness including ADHD, dementia, mental health issues	☐	☐
Do you carry a warning card?	☐	☐
Are you pregnant?	☐	☐

Please list any medicines or tablets you are **currently taking**

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Please list any **allergies** you have including medicines, tablets, substances and latex

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What is your average consumption of alcohol per week? ......

How many days in a week do you have more than 8 units? ......

Do you smoke? If so, what is your average per week? ......

How many years have you smoked for? ......

Name and address of your doctor: ......

......

Patients Signature ...... Date ......

Dentists Signature ...... Date ......

No change 1: ...... 2: ...... 3: ......