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.

Over the last 14 days have you knowingly been in contact with anyone who has been confirmed as OR has had any symptoms of the Covid-19 virus? – YES / NO

Over the last 14 days have YOU suffered from a sore throat, high temperature, cough, loss or change in your sense of smell or taste or any illness related to the Covid-19 Virus? - YES / NO

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: .....