**Medical History - Private & Confidential   
  
Forename \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mobile\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home \* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family Doctor and address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Please tick if you wish to receive appointment reminders on mobile, work or home phone**

**Have you ever had or do you suffer from:**

1. **Bronchitis, asthma or any other chest condition?............................................................................................................. Y/N**
2. **Fainting attacks, giddiness, blackouts or epilepsy? ............................................................................................................. Y/N**
3. **Heart problems, angina, blood pressure, or stroke?........................................................................................................... Y/N**
4. **Arthritis?............................................................................................................................................................................ Y/N**
5. **Bruising or persistent bleeding following injury, tooth extraction or surgery?.................................................................... Y/N**
6. **Any infectious diseases (including HIV and hepatitis)?....................................................................................................... Y/N**
7. **Rheumatic fever? ............................................................................................................................................................... Y/N**
8. **Liver disease (jaundice or hepatitis) or kidney disease?..................................................................................................... Y/N**
9. **Any other serious illness?................................................................................................................................................... Y/N**
10. **Blood refused by the Blood Transfusion Service?................................................................................................................ Y/N**
11. **A bad reaction to general or local anaesthetic?.................................................................................................................. Y/N**
12. **Joint replacements or any other implant?........................................................................................................................... Y/N**
13. **Treatment that required you to be in hospital?................................................................................................................. Y/N**
14. **Heart or brain surgery? ...................................................................................................................................................... Y/N**
15. **Allergies to any medicines? (e.g. Penicillin), substances, (e.g. Latex / rubber) or foods?..................................................... Y/N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
    Are you:**
16. **Receiving treatment from a doctor, hospital or clinic? ....................................................................................................... Y/N**
17. **Taking Bisphosphonate medication? (e.g. Alendronic acid, Fosamax)?.............................................................................. Y/N**
18. **Taking Warfarin, Rivaroxaban (Xarelto) or Dabigatran etexilate (Pradaxa)?………………………………………………………............... Y/N**
19. **Diabetic? ........................................................................................................................................................................... Y/N**
20. **Currently taking any prescribed medicines (e.g. tablets, ointments, or inhalers, including hormone replacement therapy)?**

**Or any self-prescribed medicines (e.g. Aspirin)? Please list below.......................................................................................Y/N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you:**

1. **Have a Pacemaker?.......................................................................................................................................................... Y/N**
2. **Carry a medical warning card? .......................................................................................................................................... Y/N**

Do you regularly drink more than 14 units of alcohol per week?.........................................................................................Y/N

1. **Do you smoke tobacco products, if so, how much?............................................................................................................. Y/N**
2. **Are you currently pregnant/breastfeeding?........................................................................................................................Y/N**
3. **Do you consent to receiving details of other products and services we provide? How would you like to be contacted?**

**Post SMS E-Mail Please Do Not Contact**

**In case of emergency please contact:**

**Name: ........................................................................................   
  
Relationship to you: ................................................ Contact telephone number: .............................................**

**PLEASE SIGN AND DATE BELOW**

Oral Health Habits (Please circle as appropriate)

How frequently do you:-

Brush your teeth? Once daily Twice daily Other

Clean between your teeth?

Flossing Daily Weekly Never

Interdental Brushes Daily Weekly Never

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| --- | --- |
| **Signed** | **Date** |
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Where did you hear about us?......................................................................................