



DENTAL MEDICAL FORM

Your answers on this form will help us provide you with the safest and best dental care. If you have any questions your dentist will be glad to help. **Thank you!**

Title: Mr / Mrs / Miss / Ms / Dr

Surname: _____ Forename: _____

Address: _____

Postcode: _____ Date of Birth: _____

Email: _____

Home & mobile number: _____ Work number: _____

Do you have, or have you ever suffered from any of the following?	Please tick where applicable	
	Yes	No
Rheumatic fever (Chorea St Vitus Dance)	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
High / low blood	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Replacement heart valve	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Family history of Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Haemophilia or other bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
Family history of Haemophilia or other bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (e.g. penicillin, plasters)	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Anaemia	<input type="checkbox"/>	<input type="checkbox"/>
Family history of Sickle Cell Anaemia	<input type="checkbox"/>	<input type="checkbox"/>

Are you taking any medication?
 (e.g. injections, tablets, inhalers, ointments)
 If yes please give full details:



	Yes	No
Have you undergone any blood tests or other investigations?	<input type="checkbox"/>	<input type="checkbox"/>
If yes please give details:		
Are you currently / have you recently been under the care of your Doctor?		
Prolonged illness?	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalisation?	<input type="checkbox"/>	<input type="checkbox"/>
If yes please give full details:		
Do you carry and blood borne viruses? (e.g. Hepatitis B, Hepatitis C, HIV)	<input type="checkbox"/>	<input type="checkbox"/>
If yes please give full details:		
Have you been exposed to ionising radiation? In the head and neck region? (e.g. radiotherapy treatment)	<input type="checkbox"/>	<input type="checkbox"/>
If yes please give full details:		
Do you have any artificial joints? (e.g. hip, knee)	<input type="checkbox"/>	<input type="checkbox"/>
If yes please give full details:		
Are you taking any medication for Osteoporosis? (e.g. bisphosphonates)	<input type="checkbox"/>	<input type="checkbox"/>
Women only: Do you know, or suspect you might be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If yes please give expected due date:		
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
How many cigarettes per day?		
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
How many units per week?		
If you feel you have any medical condition that you need to discuss personally with your Dentist please tick.		
<input type="checkbox"/>		

Signature of patient / parent / guardian: _____ Date: _____

Signature of examining clinician: _____ Date: _____