Dobbin Street dental surgery

Confidential Medical History

Mr/Mrs/Miss/Ms First Name : _____ Surname_____D.O.B_____

Home Address: _____ Home Phone: _____

_____ Mobile : _____

Post Code _____ Work Phone: _____

Occupation: _____ Email: _____

Details of person to contact in an emergency:

Name: _____ Phone Number: _____

Medical Doctors Name: _____ Surgery: _____

MEDICAL HISTORY

1. Are you receiving any medical treatment at the present time? **Yes / No**
   Details: _____
2. Have you been a patient in hospital during the past two years? **Yes / No**
   Reason: _____
3. Have you taken any medicine tablets, capsules or drugs during the past two years? **Yes / No**
   Details: _____
4. Have you experienced any allergies or unusual effects from any tablets,drugs,injections or anaesthetic? **Yes / No**
   Details: _____
5. Are you, or have you been, under the care of a doctor during the past two years? **Yes / No**
   Reason: _____
6. Have you ever had any of the following? If so, please tick as appropriate.

[ ] Rheumatic Fever	[ ] Heart Trouble	[ ] High Blood Pressure
[ ] Asthma	[ ] Arthritis	[ ] Hepatitis – specify type A, B, C
[ ] Bronchitis/Chest Problems	[ ] Severe Headaches	[ ] Epilepsy
[ ] Anaemia	[ ] Diabetes	[ ] Kidney Trouble
[ ] Gastric Problems	[ ] Cold sores	[ ] Depressive illness
[ ] Drug Dependence	[ ] Pace Maker	[ ] Angina
[ ] Heart Murmur	[ ] Smoker	[ ] 14 units of alcohol a week

[ ] Other _____

7. Have you had any prosthetic surgery? (eg Heart Valve or Hip Replacement) **Yes / No**
   Details: _____
8. Woman, Are you pregnant? If so, how many months: _____ **Yes / No**
9. Are you HIV positive? **Yes / No**
10. Are you at risk to HIV exposure? **Yes / No**
11. Have you ever been advised to have antibiotic cover before dental treatment **Yes / No**
12. Have you ever experienced excessive bleeding or bruising from dental treatment? **Yes / No**
13. Do you become anxious or uncomfortable when you are having dental treatment? **Yes / No**

14. I would like to speak to a member of staff in private about my medical History **Yes / No**

We would like to take this opportunity to advise you that payment *must* be cleared at the end of each appointment. Thank you.

[ ] Cash (£/€) **[ ] Card** **[ ] Cheque (£/€)** **[ ] I am exempt from dental charges**

Signed: Patient/Parent/Guardian _____ Date: _____