I have read and understood the above details.

Patient signature: Please circle: Self Parent Guardian	Date:

I have read and understood the above details.

Dentist signature:	Date:

For each examination, please check and amend any of the above details.

Signature: Please circle: Self Parent Guardian	Date:
Signature: Please circle: Self Parent Guardian	Date:
Signature: Please circle: Self Parent Guardian	Date:
Signature: Please circle: Self Parent Guardian	Date:
Signature: Please circle: Self Parent Guardian	Date:
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Signature: Please circle: Self Parent Guardian	Date:
Signature: Please circle: Self Parent Guardian	Date:

DONOVAN'S

DENTAL PRACTICE LIMITED

Middle Street, Petworth, West Sussex GU28 0BE Telephone: 01798 343552

MEDICAL HISTORY FORM

We are asking you for information about your general health in order that treatment can be safe and effective. Please provide the contact details below, answer the questions about your health and sign the form at the end. All the information provided will be in strictly confidence and only used by the people caring for you.

Surname:	
First name:	Title:
Address: Postcode:	
Home phone:	Mobile phone:
Email:	
Occupation:	
Doctor's name, address and phone number:	
How long ago did you last receive dental treatment?	

- ☐ I consent to storage use of personal data
- ☐ I am happy to receive a text, phone call or other correspondence from the practice
- ☐ I am happy for a message to be left

Please answer the questions below by ticking 'Yes' or 'No' and fill in any details.
All information is kept in the strictest confidence.

At the moment are you/have you:	Yes	No	Details
Attending or receiving treatment from a doctor or hospital?			
Taking any prescription drugs such as medicines, tablets, capsules or inhalers?			
Taken any steroids in the last year?			
Pregnant or possibly pregnant?			
Taking Bisphosphonates (medication for menopause or osteoporosis)?			
Taking the contraceptive pill or hormone replacement therapy?			

History:	Yes	No	Details
Are you allergic to any medicines, foods or materials?			
Have you had Rheumatic fever or chorea?			
Have you had jaundice, liver/kidney problems or hepatitis?			
Have you had any heart problems including angina, heart valve problems or had a heart attack?			
Do you suffer from high or low blood pressure and is it controlled?			
Do you have a pacemaker or had heart surgery?			
Have you had any blood tests or inoculations?			
Do you bleed or bruise easily?			
Has your blood ever been refused by the transfusion service?			
Have you ever had a bad reaction to an anaesthetic?			

History:	Yes	No	Details
Have you had any bone or joint diseases?			
Have you had a joint replacement?			
Have you had brain surgery?			
Have you had growth hormone treatment before mid-1980s?			
Has a close relative got Creutzfeldt-Jakob disease?			
Do you suffer from hayfever, eczema or any other allergy?			
Do you suffer from bronchitis, asthma or any other lung conditions?			
Do you have fainting attacks, blackouts or epilepsy?			
Do you, or any close family have diabetes?			
Do you carry any warning cards?			
Do you get cold sores?			
Do you have any other infectious disease (such as HIV or hepatitis) or been in contact with anyone who has?			
Do you have any other serious illnesses or had any other operations?			
Do you take any self-prescribed medication?			

Alcohol and tobacco:	Yes	No	Details
Do (or did) you smoke?			If yes, how many?
Do (or have you) chewed tobacco or any other chewing products?			
How many units of alcohol do you drink in a week? (A unit is half a pint of beer, one glass of wine, or a single spirit)	–	–	