**Dunstable Dental Practice: Medical History Form**

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|---|---|---|---|
| Name: | | | |
| Date of Birth: | | | |
| Address : | | | |
| Telephone Numbers | **Home**: | **Work**: | **Mobile**: |
| | | **Are you happy to be contacted by mobile, text or email (GDPR) Yes or No Please Circle** | |
| When did you last see a dentist | | **Email Address:** | |
| | | **Are you exempt from NHS treatment? Yes or No** | |
| Occupation: | | **IF YES PLEASE LET OUR RECEPTIONIST KNOW** | |
| Doctors Details: | | | |

| **DO YOU SUFFER FROM? If yes please circle the condition** | **TICK YES** | **NO** |
|---|---|---|
| Allergies to any medication eg: (penicillin)<br>Substances e.g.: (latex/ rubber or food) | | |
| A heart murmur or heart problems, angina, blood pressure problems, or stroke | | |
| Diabetes | | |
| Fainting attacks, Giddiness, Blackouts, Epilepsy | | |
| Bronchitis, Asthma or any other chest conditions | | |
| Infectious disease including HIV/AIDS | | |
| Arthritis, Bone or joint disease | | |
| Bruising or persistent bleeding following tooth extraction or surgery | | |
| **HAVE YOU EVER HAD? If yes please circle the condition** | | |
| Rheumatic fever | | |
| Liver disease, Jaundice, Hepatitis, Kidney disease | | |
| **HAVE YOU EVER HAD?** | | |
| Bad reaction to Local or General anaesthetic | | |
| Joint replacement or other implant | | |
| A pacemaker or any form of heart surgery | | |
| **ARE YOU CURRENTLY?** | | |
| Pregnant | | |
| Carrying a warning card | | |
| Taking any medication, please write below or hand in your repeat prescription | | |
| Have you been prescribed Bisphosphate treatment either tablet or injection | | |
| Do you smoke any tobacco products? If yes, how many per day<br>Do you chew tobacco pan, use gutkha or supari | | |
| **Smokers**: Are you interested in receiving smoking cessation advice? | | |
| Do you drink alcohol? If yes, how many units per week<br>Glass of wine 125ml-1.7 units 175ml – 2.3 units<br>Can of beer 440ml – 1.8 units Pint 568ml 2.3 units | | |
| **DO YOU CONSIDER YOURSELF TO HAVE ANY DISABILITY?** | | |

| | | | |
|---|---|---|---|
| Signed by: | Patient / Parent / Guardian / Other (Please State) | | |
| Patient: | | Date: | |
| Dentist | | Date: | |

**Please sign if you read and fully understand our Cancellation and Non-attendance Policy**
**For Further information on Data Protection 2018 (GDPR) Ask to see our PRIVACY NOTICE**