To obtain the safest treatment, your dentist needs to know of any problems which may affect your treatment

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| TITLE: | NAME: | D.O.B | M/F |
| ADDRESS: |
| EMAIL: |
| TEL: | MOBILE TEL: |
| PREFERRED WAY OF CONTACT: |
| NEXT OF KIN (NAME & NO.): |
| EXPECTANT MOTHER? Y/N  | HOW LONG SINCE LAST DENTAL APP? |
| GP NAME & ADDRESS: |

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|  | **If YES provide DETAILS in box provided:** | YES | NO | DETAILS |
| 1 | ARE YOUAttending or receiving treatment from a doctor, hospital, clinic or specialist? |  |  |  |
| 2 | Taking any medicines from your doctor? (tablets, creams, injections or other) (Extra space on back if needed) |  |  |  |
| 3 | Taking or taken steroids in the last 2 years? |  |  |  |
| 4 | **Allergic to any** **medicines**, food or materials? |  |  |  |
| 1 | HAVE YOUHad Rheumatic fever or Chorea (St. Vitus dance)? |  |  |  |
| 2 | Had jaundice, liver, kidney disease or hepatitis? |  |  |  |
| 3 | Ever been told you have a heart murmur or heart problem. Angina, blood pressure, heart attack? |  |  |  |
| 4 | Had any infectious diseases (including Hepatitis & HIV)? |  |  |  |
| 5 | Had a bad reaction to a general or local anaesthetic? |  |  |  |
| 6 | Been hospitalised? If YES what for and when? |  |  |  |
| 1 | DO YOUHave a hip replacement? |  |  |  |
| 2 | Have a pacemaker, or have you had any form of heart surgery? |  |  |  |
| 3 | Suffer from hay fever, eczema or any other allergy? |  |  |  |
| 4 | Suffer from bronchitis, asthma or any other chest condition? |  |  |  |
| 5 | Have fainting attacks, giddiness, blackouts or epilepsy? |  |  |  |
| 6 | Do you or any member of your family suffer from diabetes? |  |  |  |
| 7 | Bruise easily or following a tooth extraction, surgery or injury have you or your family bled so as to cause you to be worried? |  |  |  |
| 8 | Carry a warning card? |  |  |  |
| 9 | Ever get cold sores? |  |  |  |
| 10 | How many units of alcohol do you drink per week? |  |  |  |
| 11 | Do you smoke any tobacco products now (did you in the past?) If yes, how many per day? |  |  |  |
| Are there any other aspects concerning your health that you think the dentist should know about? |  |  |  |

The above information is for the use of the Dentist and is held in accordance with the Data Protection Act 2018

Completed by: Self / Parent / Guardian:

Date……………………Patient signature…………………………………………Dentist signature………………………………….

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| MEDICATION LIST |
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| DATE | ANY CHANGES? | LIST CHANGES BELOW | PATIENT INITIALS  | DENTISTINITIALS |
|  |  |  |  |  |