LERWICK DENTAL PRACTICE CONFIDENTIAL MEDICAL HISTORY FORM

Name:			
Date of Birth:	___ / _____ / _____	Sex:	Please circle Male Female
Address:			
Telephone (Home and Work):		Occupation:	
GP:			
Last visited dentist:			
How many times a day do you brush your teeth?			
Complaining of?			

	YES	NO	DETAILS
Are you under treatment from your doctor or hospital			
Are you taking ANY tablets, medicines, pills etc			
Have you had steroids in the past two years			
Are you pregnant			
Are you allergic to any medicines or substances			
Have you had a test for HIV			
Have you ever had rheumatic fever			
Have you ever had MRSA			
Have you or a family member had CJD			
Are you allergic to penicillin			
Do you suffer from high blood pressure			
Have you ever had angina or a heart attack			
Have you had a heart murmur or heart surgery			
Do you have a pacemaker			
How much alcohol do you consume per week			…….units per week
Have you had a bad reaction to local anaesthetic			
Have you been in hospital in the last two years			
Do you suffer from asthma or bronchitis			
Do you smoke, if so how many a day			number per day……
Do you suffer from epilepsy or have blackouts			
Do you or your family have diabetes			
Do you take anticoagulants or warfarin			
Do you need treatment for bleeding after extractions			
Do you carry any warning cards			
Are there any things that you think we need to know about your health			

Completed by self / parent / guardian Date: ___ / _____/_____

Signature:

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