LERWICK DENTAL PRACTICE CONFIDENTIAL MEDICAL HISTORY FORM

Date of Birth:/ Sex: Please circle Male Female Address:	Name:				
Telephone (Home and Work): 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 meumatic fever 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 Have you bad 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 suffer from epilepsy or have blackouts Do you suffer from epilepsy or have blackouts Do you take anticoagulants or warfarin Do you need treatment for bleeding after extractions Do you carry any warning cards	Date of Birth:	//	Sex:		
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Do you suffer from asthma or bronchitis Do you smoke, if so how many a 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	Have you had a bad re	action to local anaesthetic			
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Do you take anticoagulants or warfarin Do you need treatment for bleeding after extractions Do you carry any warning cards	Do you suffer from epilepsy or have blackouts				
Do you need treatment for bleeding after extractions Do you carry any warning cards	Do you or your family	have diabetes			
Do you carry any warning cards	Do you take anticoagu	lants or warfarin			
	Do you need treatment for bleeding after extractions				
Are there any things that you think we need to know	Do you carry any warr	ning cards			
about your health	Are there any things that you think we need to know about your health				

Completed by self / parent / guardian	Date: _	/	 /
Signature:			

LERWICK DENTAL PRACTICE CONFIDENTIAL MEDICAL HISTORY FORM

Name:					
Date of Birth:	/ /	Sex	:	Please circle	
				Male Female	
Address:		•			
Telephone (Home and Work):		Occ	upation	n:	
GP:					
Last visited dentist:					
How many times a day	do you brush your teeth?				
Complaining of?		•			
		YES	NO	DETAILS	
Are you under treatme	nt from your doctor or hospital				
Are you taking ANY ta	ablets, 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	r HIV				
Have you ever had rhe	umatic fever				
Have you ever had MR	RSA				
Have you or a family member had CJD					
Are you allergic to penicillin					
Do you suffer from high blood pressure					
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Do you need treatment	for bleeding after extractions				
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Completed by self / parent / guardian			e:/	/	

Signature: