Wensleydale Dental

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MEDICAL HISTORY

STRICTLY CONFIDENTIAL

Surname:	Title:
Forename:	Date of Birth:
Home Tel:	Work Tel:
Mobile:	E-Mail:
Address:	
Postcode:	

Certain medical conditions and medications can affect some dental treatments and/or materials.
To ensure you receive the best possible dental care, we respectfully ask that you complete the below in full or discuss the details with your dental surgeon.

Do you have or have you ever suffered with:	Please tick: Yes	No
Heart		
Rheumatic Fever	☐	☐
High or Low Blood Pressure	☐	☐
Heart Surgery	☐	☐
Pacemaker fitted	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Thrombosis	☐	☐
Other Heart Conditions:	☐	☐
Blood		
Hepatitis	☐	☐
HIV/Aids	☐	☐
Anaemia	☐	☐
Sickle Cell	☐	☐
Haemophilia	☐	☐
Abnormal Blood Test	☐	☐
Blood Refused by Transfusion Service	☐	☐
Other Blood Conditions	☐	☐
Allergies		
Penicillin	☐	☐
Latex Allergy	☐	☐
Hay Fever	☐	☐
Medicines	☐	☐
Anti Tetanus Serum	☐	☐
Eczema	☐	☐
Plants	☐	☐
Foods	☐	☐
General Anaesthetic	☐	☐
Aspirin	☐	☐
Local Anaesthetic	☐	☐
Other Allergy Conditions	☐	☐
Chest		
Bronchitis	☐	☐
Emphysema	☐	☐
Cystic Fibrosis	☐	☐
Pneumonia	☐	☐

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Do you have or have you ever suffered with: Please tick:	Yes	No
Chest Continued		
Pleurisy	☐	☐
Chest Surgery	☐	☐
Asthmatic	☐	☐
Other Chest Conditions	☐	☐
Warnings		
Hearing/Sight Impairment	☐	☐
Do Not Recline	☐	☐
Antibiotic Cover Required	☐	☐
Steroids within 2 Years	☐	☐
Bruising or Persistent Bleeding	☐	☐
Warning Card	☐	☐
Currently Under Treatment	☐	☐
Treatment Requiring Hospital	☐	☐
Other		
Liver Disease	☐	☐
Kidney Disease	☐	☐
Diabetes	☐	☐
Epilepsy	☐	☐
Acid Reflux or Eating Disorder	☐	☐
Hiatus Hernia	☐	☐
Bone or Joint Disease	☐	☐
Artificial Joint	☐	☐
Fainting Attacks or Blackouts	☐	☐
Past Serious or Infectious Disease	☐	☐
Cancer/Radiotherapy/Chemotherapy	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐
Cold Sores	☐	☐
Severe Headaches	☐	☐
Depressive Illness	☐	☐
Nervous Problems	☐	☐
Pregnant or Possibly Pregnant	☐	☐
Do you Smoke/Vape/Chew Tobacco, if so Quantity Per Day:	☐	☐
How Many Units of Alcohol do you Consume Per Week:		
Is There Anything Further you Would Directly Like to Discuss with the Clinician?	☐	☐

If you have answered yes to any questions, please supply the details below

Doctors Details

Doctors Name:

Surgery Name and Address:

Postcode:

If you are not sure of any of the questions, or if your medical circumstances change, please inform the clinician

Signed: Date: