Patient Medical History Form

Name:	
DOB	Male / Female
Doctor's Name and Address	

ARE YOU:	Yes	No	Details
An expectant Mother?			
Receiving any medication? PLEASE LIST			
Taking or have taken **steroids** in the last year?			
Allergic to any medications, foods or materials?			

HAVE YOU:

Had rheumatic fever or chorea (St. Vitus' Dance)?			
Had any **heart problems**, including heart murmur, angina, high blood pressure, heart attack or stroke?			
Had a pacemaker fitted, or any heart surgery?			
Had **Jaundice**, liver, kidney disease or Hepatitis?			
Had adverse reactions to local or general anaesthetic?			
Been Hospitalised? PLEASE GIVE DETAILS			
Had any major operations?			
Had any brain surgery, growth hormone treatment or any close relative suffering from CJD?			
Had any Psychiatric or nerve problems?			
Any infectious diseases (including HIV), or at risk of contracting these.			

DO YOU:

suffer from any **respiratory disease** such as bronchitis, asthma or TB?			
Suffer allergic disorders such as hayfever or eczema?			
Have **epilepsy,** fainting attacks or blackouts**?**			
Have **diabetes** or does anyone else in your family?			
Have any bleeding disorders, or experienced excessive bleeding following tooth removal or other surgery?			
Carry a warning card?			

IS THERE:

Other relevant information that you feel the dentist should know?

Do you smoke ? Yes / No How Many ?

How many units of Alcohol do you drink per week?

Signature	Date