

The Savernake Forest Dental Practice

TITLE	FIRST NAMES	SURNAME
DATE OF BIRTH	HOME TEL.NO.	WORK / MOBILE
HOME ADDRESS		
POSTCODE	E-MAIL.	
OCCUPATION		
HOW DID YOU HEAR ABOUT THE PRACTICE? Friend Family Member Yellow Pages Ad Web Dentist		
WHOM MAY WE THANK FOR INTRODUCING YOU?		
YOUR DOCTOR'S NAME		TEL.NO.
YOUR DOCTOR'S ADDRESS		POSTCODE

Confidential Medical History

	YES	NO	DETAILS
ARE YOU IN GOOD HEALTH?	<input type="checkbox"/>	<input type="checkbox"/>	

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS?

	YES	NO	DETAILS
HEART PROBLEMS Heart Attack, Stroke, heart murmur, angina, pacemaker, congenital heart problem, rheumatic fever, high/low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
CHEST PROBLEMS OR ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	
HEPATITIS OR JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/>	
HAVE YOU HAD SURGERY OR BEEN ADMITTED TO HOSPITAL IN THE LAST 12 MONTHS? Please detail	<input type="checkbox"/>	<input type="checkbox"/>	
ANY BLOOD DISORDERS Anaemia, leukaemia, HIV/AIDS, haemophilia. Following tooth extraction, surgery or injury have you bled so as to cause you to be worried?	<input type="checkbox"/>	<input type="checkbox"/>	
EPILEPSY Black outs/fainting attacks	<input type="checkbox"/>	<input type="checkbox"/>	
DIABETES Low blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	
COLD SORES OR MOUTH ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	

ARE YOU PRESENTLY TAKING ANY DRUG OR MEDICATION? OR ANY OF THE FOLLOWING?

	YES	NO	DETAILS
ANTIBIOTICS	<input type="checkbox"/>	<input type="checkbox"/>	
PAINKILLERS	<input type="checkbox"/>	<input type="checkbox"/>	
TRANQUILLISERS antidepressants, sedatives, sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	
ANTICOAGULANTS (blood thinners)	<input type="checkbox"/>	<input type="checkbox"/>	
DRUGS FOR HEART/CHEST PROBLEMS high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
STEROID THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	
OTHER DRUG OR MEDICATION	<input type="checkbox"/>	<input type="checkbox"/>	
DO YOU SMOKE, IF SO APPROX. HOW MANY DAILY?	<input type="checkbox"/>	<input type="checkbox"/>	
HAVE YOU REACTED ADVERSELY OR ARE YOU ALLERGIC TO ANY DRUGS MEDICATION OR ANYTHING ELSE?	<input type="checkbox"/>	<input type="checkbox"/>	
SIGNATURE	Date		