

DENTAL LOUNGE - MEDICAL HISTORY FORM

SURNAME:		TITLE:		SEX:	
FORENAME:		DOB:	_/_/____		
STREET ADDRESS:					
TOWN/CITY:		COUNTY:		POSTCODE:	
TEL: (HOME):		WORK:		MOB:	
EMAIL:			OCCUPATION:		
GP NAME:					
GP ADDRESS:					
GP NUMBER:					

Please circle YES or NO

Are you currently receiving medical treatment from a doctor/ hospital/clinic	YES	NO
NOTES:		
Are you taking any prescribed medicines?	YES	NO
NOTES:		
Do you carry a medical warning card?	YES	NO
NOTES:		
Are you pregnant?	YES	NO
NOTES:		
Are you allergic to any food, medicines or substances? E.g. latex or penicillin	YES	NO
NOTES:		
Do you have hay fever or eczema?	YES	NO
NOTES:		
Do you have bronchitis, asthma or any other chest condition?	YES	NO
NOTES:		
Do you suffer from fainting attacks, giddiness, blackouts or epilepsy?	YES	NO
NOTES:		
Do you have heart problems, angina, blood pressure problems or stroke?	YES	NO
NOTES:		
Do you or anybody in your family have diabetes?	YES	NO
NOTES:		
Do you suffer from arthritis?	YES	NO
NOTES:		
Do you have bruising or persistent bleeding following injury, tooth extraction or surgery?	YES	NO
NOTES:		

Do you have infectious diseases?	YES	NO
NOTES:		
Do you have rheumatic fever or chorea?	YES	NO
NOTES:		
Do you have liver disease or kidney disease	YES	NO
NOTES:		
Do you have any other serious illness?	YES	NO
NOTES:		
Has your blood ever been refused by the blood transfusion service?	YES	NO
NOTES:		
Have you ever had a bad reaction to local or general anaesthetic?	YES	NO
NOTES:		
Have you had a joint replacement or other implant?	YES	NO
NOTES:		
Have you had treatment which required you to be in hospital?	YES	NO
NOTES:		
Have you had heart surgery?	YES	NO
NOTES:		
Do you smoke?	YES	NO
If so, please give approximate number of cigarettes per week		
Do you chew tobacco, paan, gutka or supari now or in the past?	YES	NO
NOTES:		
Do you drink alcohol?	YES	NO
If so, please give approximate number of units per week		

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____