SPROTBROUGH
DENTAL PRACTICE

140 Sprotbrough Road, Doncaster, DN5 8BB

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Medical History Form

Title: _____ Surname: _____ Forename(s):_____ Date of Birth: ____/____/____

Full Address: _____ Postcode: _____

Telephone (Home/Mobile):_____ Sex: M F

Name of GP: _____ Full Address of GP: _____

_____

Please answer the questions below by ticking the appropriate box.	**YES**	**NO**	**Please give details**
Are you currently receiving treatment from a doctor, the hospital or clinic?			
Do you suffer from any allergies such as penicillin or substances such as latex or foods?			
Is there any other information the dentist may need to know such as self-prescribed medicines?			
Are you currently taking any prescribed medication? E.g. Tablets/inhalers/contraceptives? Please state the names of the tablets.			
Do you suffer from heart problems, angina, blood pressure, and heart murmur or had a stroke?			
Have you ever had heart surgery?			
Do you carry a warning card or have a pacemaker?			
Do you take any blood thinning medication such as Warfarin?			
Do you suffer from asthma bronchitis, COPD or any other chest conditions?			
Are you or anyone in your family diabetic and if so how is it controlled?			
Do you suffer from rheumatoid arthritis?			
Do you suffer from bruising or persistent bleeding following an injury or tooth extraction?			
Do you suffer fainting attacks, giddiness, blackouts or epilepsy?			
Do you suffer from any infectious diseases such as HIV? Or any other illness?			
Have you ever had chorea rheumatic fever, or previous infective endocarditic?			
Have you ever had liver disease or kidney disease?			
Have you ever had blood refused by the blood transfusion service?			
Have you ever had bad reaction to general or local anaesthetic?			
Have you ever had treatment that required a stay in hospital?			
Did you receive growth hormone treatment before the mid 80's?			
Do you have any close relatives with Creutzfeldt Jakob disease?			
Do you suffer from hay fever or eczema?			
Do you smoke any tobacco products, if so how many a day?			
Do you drink alcohol; if so how many units do you consume a week?			
Are you currently pregnant or breastfeeding?			

By signing below, I hereby confirm I am happy the information is correct and I am happy for it to be shared with other health professionals necessary for treatment.

Completed by (please circle one): Self/ Parent/ Guardian

Signature: _____Date: _____