



MEDICAL HISTORY FORM (For use by Lockswood Dental Practice only)

Name: Date of Birth:.....
 Address:.....
 Occupation:.....
 Tel Home/work:..... Mobile:
 Email address:.....
 GP's name / address:.....

ARE YOU? (please circle)			
1.	Attending or receiving treatment from any doctor	Y	N
2.	Taking any medicines or tablets from your doctor	Y	N
3.	Taking or have you taken any Steroids in the last two years	Y	N
4.	Allergic to any medicines, foods or materials	Y	N
5.	Likely to be pregnant	Y	N

HAVE YOU? (please circle)			
1.	Ever been jaundiced, liver, kidney disease or Hepatitis A,B or C	Y	N
2.	Ever had Rheumatic fever or been told that you have a heart murmur	Y	N
3.	Ever been told that you have a heart condition or had a heart attack	Y	N
4.	Ever had infective endocarditis, a heart valve replacement or heart surgery	Y	N
5.	High or low blood pressure	Y	N
6.	Had any blood tests recently	Y	N
7.	Ever had a major operation or recently received hospital treatment	Y	N
8.	Ever had a bad reaction to a local or general anaesthetic	Y	N
9.	Ever suffered a stroke	Y	N
10.	Ever had your blood refused by the Blood Transfusion Service	Y	N
11.	Ever been diagnosed or suspected as having CJD or being HIV positive	Y	N

DO YOU? (please circle)			
1.	Have a pacemaker	Y	N
2.	Suffer from bronchitis or asthma	Y	N
3.	Bruise easily or have you ever bled excessively	Y	N
4.	Have fainting attacks, giddiness or epilepsy	Y	N
5.	Have diabetes	Y	N
6.	Carry a warning card	Y	N
7.	Smoke, if so how many	Y	N
8.	Have you ever smoked in your life	Y	N
9.	Drink alcohol, if so how many units a week..... units	Y	N

If there are any other aspects to your health that we feel we should know about or if you have answered YES to any of the above questions, PLEASE GIVE DETAILS OVERLEAF

Signed:..... Date:.....

Signed:..... Date:.....