NAME: Title:	
DATE OF BIRTH:	SEX:
ADDRESS:	Postcode:
TEL NO: HOME:	WORK:
OCCUPATION:	HOW LONG SINCE LAST DENTAL
YOUR DOCTOR'S NAME, ADDRESS:	

	Yes	No	Details
ARE YOU:An expectant mother?			.
Receiving medical treatment?			.
Taking any medication?			.
Taking or have you taken steroids in the past two years?			. .
Allergic to any medicines, foods or materials?			.
HAVE YOU:Had rheumatic fever or chorea?(St Vitus Dance)			. .
Had jaundice, liver, kidney disease or hepatitis?			.
Had any heart problems, a heart murmur, angina, high blood pressure, or a heart attack?			. .
Had any blood tests, inocculations etc?			.
Ever had a blood donation refused by the Blood Transfusion Service?			. .
Adverse reaction to either a local anaesthetic or a general anaesthetic?			. .
Had a joint replacement?			.
Been hospitalised? if YES what for and when			.
DO YOU:Suffer from arthritis?			.
Have a pacemaker, or had any form of heart surgery?			. .
Suffer from allergic disorders such as Hay Fever or Eczema?			. .
Suffer from any Respitory disease such as Bronchitis or Asthma?			. .
Have epilepsy, fainting attacks, giddiness or blackouts?			. .
Have diabetes or does anyone in your family?			.
Bruise easily following a tooth extraction, surgery or injury or do you or your family have bleeding disorders?			. . .
Carry a warning card?			.
Ever got cold sores?			.
Any other relevant medical information that the dentist should know about?			. .
How many cigarettes do you smoke per day?			.
Do you or any close relative suffer from CJD?			.
High Blood Pressure			.
HIV			.
Ecoli			.
MRSA			.

Completed by:Self/Patient/Guardian Signature ....

Date ....