# Ashby Fields Dental Centre

To give the best and safest treatment your dentist needs to know of any medical conditions which may affect your dental treatment.

Title | Surname | First names

Address

Postcode | Email address

Date of Birth | Contact Numbers

Home:

Mobile:

GP Details

Next of kin

| ARE YOU CURRENTLY | YES | NO | GIVE DETAILS |
|---|---|---|---|
| Receiving treatment from a doctor, hospital or clinic? | | | |
| Taking any prescribed medicines (eg tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy | | | |
| Carrying a medical warning card? | | | |
| Fitted with a pacemaker? | | | |

| DO YOU SUFFER FROM | YES | NO | GIVE DETAILS |
|---|---|---|---|
| Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods? | | | |
| Hay fever or eczema? | | | |
| Bronchitis, asthma or other chest condition? | | | |
| Fainting attacks, giddiness, blackouts or epilepsy? | | | |
| Heart problems, angina, blood pressure problems or stroke? | | | |
| Diabetes (or does anyone in your family) | | | |
| Arthritis? | | | |
| Bruising or persistent bleeding following injury, tooth extraction or surgery? | | | |
| Any infectious disease (including HIV and Hepatitis)? | | | |
| Anemia, Sickle cell or hemophilia? | | | |

***Please turn over and complete back page***

| DID YOU, AS A CHILD OR SINCE, HAVE: | YES | NO | GIVE DETAILS |
|---|---|---|---|
| Liver disease (eg jaundice, hepatitis) or kidney disease? | | | |
| Any other serious illness? | | | |
| A bad reaction to a local or general anaesthetic? | | | |
| A joint replacement? | | | |
| A joint replacement or other implant? | | | |
| Treatment that required you to be in the hospital? | | | |
| Heart surgery? | | | |
| Brain surgery | | | |
| A close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease? | | | |

| DRINKING | UNITS PER WEEK |
|---|---|
| How many units of alcohol do you drink per week?<br>*(A unit is half a pint of beer, lager or cider, a single measure of spirits or a small glass of wine/aperitif)* | |

| SMOKING AND CHEWING | YES | NO | IN THE PAST | QUANTITY |
|---|---|---|---|---|
| Do you smoke any tobacco products now (or did you in the past) How many times per day? | | | | |
| Do you chew tobacco, pan, gutkha or supari now (or did you in the past)? How many times per day? | | | | |

| FEMALE PATIENTS, ARE YOU LIKELY TO BE PREGNANT? | YES | NO | *Expected date of delivery* |
|---|---|---|---|
| | | | |

| **Are you currently exempt from dental charges? If so please state below your exemption.** | YES | NO |
|---|---|---|
| | | |

**FORM COMPLETED BY (Please tick)** Self ☐ Parent ☐ Guardian ☐

| SIGNATURE | DATE |
|---|---|
| | |

We send SMS and Email reminders with the day and time of your appointment. If you are NOT happy to receive these please tick the box. ☐

Thank you for completing this medical history form
**All details will be strictly confidential**