TITLE FORENAME SURNAME ______________________
DATE OF BIRTH _________________
ADDRESS ________________________
TEL NO. _____
WORK TEL. ____________________ **MOBILE.** ____________
EMAIL ADDRESS
DOCTORS NAME AND ADDRESS___________________________________

IF YOU ANSWER YES TO ANY OF THE QUESTION BELOW PLEASE GIVE DETAILS. (eg. medication name)

Are you currently receiving treatment from a doctor, hospital or clinic? YES/NO
Are you taking steroids? YES.NO
Are currently taking any prescribed medicines (eg tablets, ointments or inhalers, including contraceptives and hormone replacement therapy) YES/NO
Do you suffer from allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods? YES/NO
Do you smoke any tobacco products now? YES/NO
If yes, how many per day do you smoke? ________________________________
Have you ever smoked any tobacco products? YES/NO
If yes, when approximately did you stop?__________________________________
Do you or have you ever chewed tobacco, pan, use gutkha or supari now (or did you in the past)? YES/NO
Do you regularly drink more than 14 units of alcohol per week? YES/NO
How many units of alcohol do you drink per week?___________________________
(A unit is half a pint of lager, a single measure of spirits or a single glass of wine)
Have you ever had rheumatic fever or chorea? YES/NO
Have you ever had liver disease (eg jaundice, hepatitis) or kidney disease? YES/NO
Do you suffer from heart problems, angina, blood pressure problems, Or stroke? YES/NO
Do you suffer from Hay fever or eczema? YES/NO
Do you suffer from fainting attacks, giddiness, blackouts or epilepsy? YES/NO
Do you suffer from bronchitis, asthma or other chest conditions? YES/NO
Are you diabetic (or is anyone in your family)? YES/NO
Do you suffer from arthritis? YES/NO
Do you suffer from bruising or persistent bleeding following injury, tooth extraction or surgery? YES/NO
Do you suffer from any infections, diseases (including HIV and hepatitis) YES/NO
Are you carrying a medical warning card? YES/NO
Have you ever had blood refused by the Blood Transfusion Service? YES/NO
Have you ever had a bad reaction to general or local anaesthetic? YES/NO
Have you ever had a joint replacement or other implants? YES/NO
Have you ever had heart surgery? YES/NO
Have you ever had treatment that required you to be in hospital? YES/NO
Have you ever had brain surgery? YES/NO
Did you receive growth hormone treatment before the mid 1980’s? YES/NO
Did you have any close relatives (parent,sibling, child, grandparent or Grandchild) with Creutzfeldt jakob disease? YES/NO
Is there any other information which your dentist might need to know? YES/NO
Are you pregnant? YES/NO
Have you ever taken or are you currently taking Bisphosphonates? YES/NO

Completed by Self/Parent/guardian Signature :_________________ Date:______

Signature of dentist:______________________

ADDITIONAL INFORMATION.