|  |  |
| --- | --- |
| Name | Hospital No |
| Address | Date of Birth |
| Postcode |



**Medical History Form**

**Parent or Guardian – please complete on the patient’s behalf**

|  |
| --- |
| **Are you currently**: if yes, please give details (continue overleaf if necessary) |
| Receiving treatment from a doctor, hospital, clinic or specialist? | Yes □ | No □ |
| Taking any medication? | Yes □ | No □ |
| Carrying a medical warning card? | Yes □ | No □ |
| **Do you suffer from any of the following?** |  |  |
| Heart problems, including heart murmur, high blood pressure? | Yes □ | No □ |
| Chest problems, including asthma, bronchitis? | Yes □ | No □ |
| Kidney disease? | Yes □ | No □ |
| Diabetes (you or anyone in your family)? | Yes □ | No □ |
| Allergies to any substances, including medicines? | Yes □ | No □ |
| Epilepsy, fainting attacks or blackouts? | Yes □ | No □ |
| Bruising or persistent bleeding following injury, tooth extraction or surgery? | Yes □ | No □ |
| **Have you ever had:** |  |  |
| A bad reaction to General or Local Anaesthetics? | Yes □ | No □ |
| Any serious illness? | Yes □ | No □ |
| If there is anything else you would like to discuss but prefer not to write down, please tick here and the Dentist will discuss this with you. | □ |

Signature of patient/parent/guardian:……………………………………………………………….Date:……………………….