THE CHURCH ROAD
DENTAL PRACTICE

Patient Medical History

THE CHURCH ROAD DENTAL PRACTICE
104A Church Road
London
NW10 9QH
0208 459 4804

MR/MRS/MS/MISS/MAST:.....
PATIENT NAME: .....
.....

ADDRESS:.....
.....
.....
POSTCODE: .....
HOME/WORK NO: .....
MOBILE NO: .....
EMAIL: .....
DATE OF BIRTH: .....
CURRENT AGE: .....

CURRENT GP:	**PREVIOUS DENTIST:**
Name: ..... Address: .... Postcode: ..... Tel:	Name: ..... Address: .... Postcode: ..... Tel: .....

Certain medical conditions can affect dental treatment and vice versa. Please complete this form by ticking the appropriate boxes and answering the questions

How long since your last dental visit? .....

ARE YOU CURRENTLY:
An expectant mother? ☐ Yes ☐ No
.....
Receiving treatment from a doctor, hospital or clinic? ☐ Yes ☐ No
What treatment are you receiving and which GP, Hospital or clinic is in charge of your treatment? .....
.....
.....
.....
Taking any prescribed medicines?
(e.g. tablets, ointments, injections, inhalers including contraceptives and HRT) ☐ Yes ☐ No
.....
.....
.....
Do you carry a warning card? ☐ Yes ☐ No
.....

DO YOU SUFFER FROM:
Allergies to any medicines (e.g. Penicillin) ☐ Yes ☐ No
.....
Allergies to substances or foods? ☐ Yes ☐ No
.....
Hay fever or eczema? ☐ Yes ☐ No
.....

Bronchitis, Asthma or any other chest condition? ☐Yes ☐ No

……

Fainting attacks, giddiness, blackouts or epilepsy? ☐ Yes ☐ No

……

Heart problems, angina, blood pressure problems or strokes? ☐Yes ☐ No

……

Diabetes (or does any one in your family)? ☐ Yes ☐ No

……

Arthritis? ☐ Yes ☐ No

……

Bruising or persistent bleeding following injury, tooth extractions or surgery? ☐ Yes ☐ No

……

Any infectious diseases inc (HIV and hepatitis)? ☐ Yes ☐ No

……

DID YOU AS A CHILD OR SINCE HAVE:

Rheumatic fever or chorea? ☐ Yes ☐ No

……

Liver or kidney disease (e.g. jaundice, hepatitis)? ☐ Yes ☐ No

……

Any other serious illness? ☐ Yes ☐ No

……

A bad reaction to a local or general anaesthetic? ☐ Yes ☐ No

……

A joint replacement or other implant? ☐Yes ☐ No

……

Treatment that requires you to be In hospital? ☐ Yes ☐ No

……

Heart surgery or brain surgery? ☐ Yes ☐ No

……

Growth hormone treatment before the mid 1980's? ☐ Yes ☐ No

……

A close relative (parent, sibling, child, grandparent or grandchild with creutzfeldt jakob disease (CJD)? ☐ Yes ☐ No

……

Do you smoke any tobacco products now or did you in the past? If yes, how many times per day? ☐ Yes ☐ No

……

Do you drink alcohol? If yes how many units do you drink in a week? (one unit = one pint/glass of wine/single measure of spirits) ☐ Yes ☐ No

……

If you have ticked any of the boxes above, please provide more details below including any prescribed or non-prescribed medication you are taking:

……

……

……

……

If you are not sure of any of the questions, or if your medical circumstances change, please inform the Dental Surgeon

NEXT OF KIN DETAILS:

Name: ……

Relationship: ……

Tel: ……

Email: ……

TO THE BEST OF MY KNOWLEDGE, ALL THE INFORMATION GIVEN ON THIS FORM IS ACCURATE AND COMPLETE

SIGNED: ……

DATE: ……

I am the patient/guardian/carer (please delete as appropriate)

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

DATE	NO CHANGE	CHANGES	PATIENT'S INITIALS