MEDICAL INFORMATION

Please complete the following form as fully and accurately as possible. If you are happy for us to contact you via email with regards to your dental appointments, please also provide your preferred email address.

Full name: ..... **Date of birth:** .....

Tel. No: ..... **Email** .....

GP's name: ..... **GP Practice:** .....

MEDICAL INFORMATION	PLEASE TICK	PLEASE GIVE DETAILS BELOW
Do you have any medical conditions at present?	☐ Yes ☐ No	
Do you or any family members currently have symptoms of coronavirus?	☐ Yes ☐ No	
Do you take any medicines? Please list prescription and non-prescription medication and the dosage if known. (additional space below)	☐ Yes ☐ No	
Have you ever had cancer? If so when and what type?	☐ Yes ☐ No	
Do you have or have you ever had any heart problems? e.g. heart disease, heart attack, heart murmur, angina	☐ Yes ☐ No	
Do you have a pacemaker?	☐ Yes ☐ No	
Do you have high/low blood pressure?	☐ High ☐ Low	
Do you have high cholesterol?	☐ Yes ☐ No	
Have you ever had rheumatic fever or infective endocarditis?	☐ Yes ☐ No	
Have you ever had a stroke, blood clot, or DVT?	☐ Yes ☐ No	
Do you have a blood clotting disorder? e.g. haemophilia, von Willebrand's disease, low platelets.	☐ Yes ☐ No	
Do you take any medicines that affect blood clotting? e.g. Warfarin, Clopidogrel, Rivaroxaban, Apixaban	☐ Yes ☐ No	
Do you suffer from any chest or breathing problems? e.g. asthma, bronchitis, COPD, TB	☐ Yes ☐ No	
Do you have any liver problems?	☐ Yes ☐ No	
Do you have any kidney problems?	☐ Yes ☐ No	
Do you have diabetes?	☐ Yes ☐ No	☐ Type 1 ☐ Type 2

Do you have epilepsy?	☐ **Yes** ☐ **No**	

Do you have, or have you ever had, any infectious diseases? e.g. hepatitis, HIV/AIDS, CJD-Creutzfeldt-Jacob disease.	☐ **Yes** ☐ **No**	
Do you suffer from cold sores?	☐ **Yes** ☐ **No**	
Do you have any allergies? What are you allergic to? e.g. latex, penicillin.	☐ **Yes** ☐ **No**	
Do you have any mobility problems? e.g. arthritis, back/neck problems, difficulty using stairs	☐ **Yes** ☐ **No**	
Do you consider yourself to have a disability?	☐ **Yes** ☐ **No**	
Is your weight greater than 20 stone (127kg)?	☐ **Yes** ☐ **No**	
Are you awaiting any medical tests or test results?	☐ **Yes** ☐ **No**	
Are you pregnant?	☐ **Yes** ☐ **No**	**Due date if known**
Do you smoke or chew tobacco?	☐ **Yes** ☐ **No**	☐ **In the past**
Do you drink alcohol?	☐ **Yes** ☐ **No**	**Units per week**
Have you ever had a bad reaction to a local anaesthetic?	☐ **Yes** ☐ **No**	
Do you feel anxious about dental treatment?	☐ **Yes** ☐ **No**	

Patient declaration: I confirm that I have provided accurate and full information on my past and present health status and agree to update the practice on any changes to this at each appointment.

Signature: …… Date: ……

Any additional information or medication:-