Medical History Form
The Village Dentists

Surname (Mr/Mrs/Miss/Ms) ____________________

Forename ____________________

Address ____________________

. ____________________ Postcode ____________________

Tel No (Home) ____________________ Tel No. (Mobile/Work): ____________________

Date of Birth: ____________________ Occupation: ____________________

How would you like to receive appointment reminders/ correspondence from The Village Dentists: Text ☐ Letter ☐ Phone ☐

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

All details will be strictly confidential

Do you have or have you ever suffered from:	**YES**	**NO**		**YES**	**NO**
Rheumatic fever? …………………………………..	☐	☐	Hepatitis? …………………………..	☐	☐
Any heart complaint, heart surgery or stroke? ………	☐	☐	Excessive bleeding? …………………..	☐	☐
Diabetes? ………………………………………….	☐	☐	High blood pressure? ………………..	☐	☐
Epilepsy or fainting attacks? ………………………..	☐	☐	Any other serious illness?….…………	☐	☐
Chronic bronchitis or asthma? ………………………	☐	☐	Do you carry a medical warning card?	☐	☐
Tick or **tell the Dentist** if you are HIV positive	☐	☐	Are you Pregnant	☐	☐

Are you:

	YES	NO
Allergic to **any** medicine, tablets, substances or latex? (List below) ………………..……………………………………………………………………………………….	☐	☐
At present taking any medicine or tablets? (List medication below) …………………………………………………………………………...……………………………….. ……	☐	☐

In the past 2 years:

	YES	NO
Have you undergone any operations? ……………………………………………. …………………………………………………………………….	☐	☐
Have you been treated with hydro-cortisone or corticosteroids? …………………………..………………………………………………………………………	☐	☐
Have you ever had a joint replacement operation? ……..	☐	☐

How many units of alcohol do you drink per week?................. If you smoke, how many per week?.......................

Have you ever had a bad reaction to general or local anaesthetic? ………………………………………

If 'Yes' to any question please supply details below or use back of form

……

Name and address of your doctor: ……………………………………………………………………

……

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

Patient/Parent?Guardian signature ____________________ Date ____________