

TITLE:	FIRSTNAME:	SURNAME:
DATE OF BIRTH:	SEX (MALE/FEMALE):	OCCUPATION:
TEL (HOME):	(WORK):	(MOBILE):
ADDRESS:		
EMAIL:	INSURANCE COVER (VHI DECARE ETC):	
REFERRED/RECOMMENDED BY:	PREFERRED CONTACT METHOD (EMAIL/POST):	
GP NAME & ADDRESS:		
DENTIST NAME & ADDRESS:		
NEXT OF KIN: NAME	TEL:	RELATIONSHIP:

	Yes	No	If yes, please detail
1. Are you attending a doctor for any specific complaint?			_____
2. Are you taking any medications at present? e.g. aspirin, anti-coagulants, contraceptive pill, osteoporosis medication			_____
3. If female, are you pregnant?			<u>Expected due date?</u>
4. Have you ever taken long-term steroids or immunosuppressive drugs?			_____
5. Have you ever been hospitalised?			_____
6. Have you ever had an adverse reaction to general or local anaesthetic or sedation?			_____
7. Have you ever had excessive bleeding or bruising following a tooth extraction or cut?			_____

Have you ever had:	Yes	No	If yes, please detail

8. Heart complaint e.g. Angina (chest pain), attack, murmur, surgery

9. High blood pressure

10. Deep vein thrombosis (DVT) or clot

11. Radiation therapy or chemotherapy

12. Jaundice, liver or kidney disease



**CONFIDENTIAL
MEDICAL
HISTORY
FORM**
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Do you suffer from:	Yes	No	If yes, please detail
13. Anemia			<hr/>
14. Arthritis, osteoporosis or joint condition			<hr/>
15. Asthma, bronchitis or chest condition			<hr/>
16. Allergies e.g. Penicillin, latex, any medication			<hr/>
17. Cold sores			<hr/>
18. Diabetes			<i>What type? Since when?</i> <hr/>
19. Epilepsy or Fainting			<hr/>

20. Hepatitis or any blood-borne virus

21. Stomach ulcer or stomach condition

22. Thyroid disease

Do you:

Yes

No

If yes, please detail

23. Smoke

*How many per day?
Since when?*

24. Drink Alcohol

*How much per
week?*

Yes

No

If yes, please detail

25. Are there any other aspects concerning your health that you think your oral surgeon should know about?

26. Do you carry a warning card?

Would you like to be contacted in the future about our practice newsletter?

I, the undersigned, certify that to the best of my knowledge, the information provided on this medical history form is correct. I understand that the information provided here will be kept strictly confidential and will not be made publicly available without my consent.

Completion Date:
by:

Completed

If you have any queries regarding the health or aesthetics of your smile, we would be happy to discuss these during your consultation.