

Are you currently

yes

no

Give details

Receiving treatment from a doctor, hospital or clinic?

Taking any prescribed medicines (eg tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?

Carrying a medical warning card?

Pregnant or possibly pregnant?

Have you ever suffered from

yes

no

Give details

Allergies to medicines (eg penicillin), substances (eg latex/rubber) or foods?

Bronchitis, asthma or other chest condition?

Fainting attacks, giddiness, blackouts, epilepsy?

Heart problems, angina, blood pressure problems, or stroke?

Diabetes (or does anyone in your family)?

Bone or joint disease?

Bruising or persistent bleeding following injury, tooth extraction or surgery?

Liver disease (eg jaundice, hepatitis) or kidney disease?

Any other serious illness or infectious disease?

Blood refused by the Blood Transfusion Service?

A bad reaction to general or local anaesthetic?

Completed by (please tick)

self

parent

guardian

Patient's signature _____ Date _____

Dentist's signature _____ Date _____

Medical history update

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	List any changes below	Patient's initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____