Rowcroft Dental Centre Ltd - Patient Medical History Form

Name:	
DOB:	Male / Female
Doctor's Name and Address:	

ARE YOU?	YES	NO	Details
An expectant mother?:			
Receiving any medication: *Please list*			
Taking or having taken steroids in the last year?:			
Allergic to any medications, foods or materials?			

HAVE YOU?	YES	NO	Details
Had Rheumatic Fever or Chorea (St. Vitus' Dance)?:			
Had any heart problems including heart murmur, Angina, high blood pressure, heart attack or stroke?:			
Had a pacemaker fitted, or any heart surgery?			
Had Juandice, liver, kidney disease or Hepatitis?			
Been hospitalised? *Please give details*			
Had any major operations?			
Had adverse reactions to local or general anaesthetic?			
Had any brain surgery, growth hormone treatment or any close relative suffering from CJD?			
Had any psychiatric or nerve problems?			
Any infectious diseases (including HIV) or at risk of contracting these?			

DO YOU?	YES	NO	Details
Suffer from any respiratory disease such as Brochitis, Asthma or TB?:			
Suffer allergic disorders such as Hayfever or Eczema?:			
Have Epilepsy, fainting attacks or blackouts?			
Have Diabetes or does anyone in your family?			
Have any bleeding disorders, or experience excessive bleeding following tooth removal or other surgery?:			
Carry a warning card?:			

IS THERE:

Other relevant information that you feel the dentist should know?

Do you smoke? YES ☐ NO ☐ How many? ☐

How many units of alchohol do you drink per week? ☐

Signature	Date