Rowcroft Dental Centre

Patient Medical History Form

Name:
D.O.B:
Male / Female

Lifestyle			
Do you smoke?	No	Yes	If yes, how many per day:
Do you drink alcohol?	No	Yes	If yes, how many units per week:
Is your diet high in sugar/ or high frequency?	No	Yes	If yes, please give details:
Do you drink a lot of fizzy or acidic drinks?	No	Yes	
Do you use recreational drugs?	No	Yes	
Are you or could you be pregnant?	No	Yes	
Is there anything else the dentist should know?			

Heart			
Rheumatic fever	No	Yes	
High/Low blood pressure	No	Yes	
Heart surgery	No	Yes	
Pacemaker fitted	No	Yes	
Heart murmur	No	Yes	
Angina	No	Yes	
Thrombosis	No	Yes	
Other heart conditions	No	Yes	

Blood			
Hepatitis A,B,C,D	No	Yes	
H.I.V/ AIDS	No	Yes	
Abnormal blood tests	No	Yes	
Blood refused by transfusion service	No	Yes	
Anaemia	No	Yes	
Sickle cell	No	Yes	
Haemophilia	No	Yes	
Other blood conditions	No	Yes	If yes please give details:

Allergies			
Penicillin	No	Yes	
Hay fever	No	Yes	
Anti – tetanus serum	No	Yes	
Eczema	No	Yes	
General Anaesthetic	No	Yes	
Local Anaesthetic	No	Yes	
Latex Allery	No	Yes	
Medicine	No	Yes	
Plants	No	Yes	
Food	No	Yes	
Aspirin	No	Yes	
Other allergy	No	Yes	
Warnings			If yes please give details:
Do you have hearing or sight impairment?	No	Yes	
Do you require Antibiotic Cover?	No	Yes	
Do you have bruising or president bleeding after injury, surgery, or tooth extraction?	No	Yes	
Are you currently having treatment from a doctor, hospital, or clinic?	No	Yes	
Have you ever had treatment that required you to be hospitalised?	No	Yes	
Do you have a problem being reclined?	No	Yes	
Have you had steroids in the last 2 years?	No	Yes	
Do you carry a warning card?	No	Yes	
Chest			If yes please give details:
Bronchitis	No	Yes	
Cystic Fibrosis	No	Yes	
Pleurisy	No	Yes	
Asthma	No	Yes	
Emphysema	No	Yes	
Pneumonia	No	Yes	
Chest surgery	No	Yes	
Other chest condition	No	Yes	

Medication

Please list and state dose of any prescribed medicines, tablets, ointments, injections, or inhalers:

Other Conditions			If yes please give details
Liver disease	No	Yes	
Diabetes/ family with diabetes	No	Yes	
Acid reflux or eating disorders	No	Yes	
Bone or joint disease	No	Yes	
Fainting attacks or blackouts	No	Yes	
Any past or serious illness or infectious disease	No	Yes	
Depressive illness	No	Yes	
Nervous problems	No	Yes	
Severe headaches	No	Yes	
Cold sores	No	Yes	
Tuberculosis	No	Yes	
stroke	No	Yes	
Cancer/ radiotherapy	No	Yes	
Giddiness	No	Yes	
Artificial joint	No	Yes	
Hiatus hernia	No	Yes	
Epilepsy	No	Yes	
Kidney disease	No	Yes	
	No	Yes	

Doctor:
Name of Doctor:
Contact number for Doctor:
Medical Practice:

Who should we contact in an emergency:
Emergency contact name:
Emergency contact phone number:
Emergency contact relationship:

Signature

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Date

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