Abbeymead Dental Care

CONFIDENTIAL MEDICAL HISTORY

Name:	Date of Birth:
Address:	Telephone numbers: Home: Work: Mobile:
Email Address:	
Occupation:	
Doctors Name & Address:	

How would you prefer us to contact you?
Telephone: home [ ] work [ ] Mobile [ ] Email [ ] Letter [ ]

How did you hear about us?____

	Yes	No	Please give Details
Are you generally fit & well?			
Are you being treated by your GP for anything at the moment?			
Do you take any medication either prescribed by your GP or homeopathic on a regular basis?			
Are you allergic to any medicines, foods or materials?			
Have you ever had heart problems eg: heart murmur, angina, high or low blood pressure or heart attack?			
Have you ever had Rheumatic fever?			
Do you suffer from Bronchitis or Asthma?			
Do you smoke? Typically how Many per day?			
Have you ever had Jaundice, Hepatitis, liver problems or kidney disease?			
Have you ever had a blood donation refused by the blood transfusion service?			
Are you ,or a close relative diabetic?			
Do you have fainting attacks, giddiness or epilepsy?			
Do you bruise easily or have you ever bled excessively?			
Have you ever had an operation or received hospital treatment?			
Have you, or anyone close to you, tested positive for HIV or AIDS?			

Please add any other information you feel is necessary.

Signature

Date