

Name: Mr/Mrs/Ms/Miss

Date of Birth: / /

Address:

Postcode:

Occupation:

Male Female

Your Doctor's Name and Address:

1. Are you an expectant mother?
 Yes No
2. Are you receiving medical treatment? (If yes, please give details)
 Yes No
3. Are you taking medication? (If yes, please give details)
 Yes No
4. Are you taking/have you taken steroids in the past two years?
 Yes No
5. Are you allergic to any medicines, foods or materials? (If yes, please give details)
 Yes No
6. Have you had any heart problems, heart murmur, angina, high blood pressure or heart attack? (If yes, please give details)
 Yes No
7. Have you had infective endocarditis?
 Yes No
8. Have you had a surgically constructed pulmonary shunt or conduit?
 Yes No
9. Have you had a cardiac valve replaced?
 Yes No
10. Do you have a pacemaker or had any form of heart surgery?
 Yes No
11. Have you had jaundice, liver, kidney disease or hepatitis? (If yes, please give details)
 Yes No
12. Have you had any blood tests, inoculations etc? (If yes, please give details)
 Yes No
13. Have you ever had a blood transfusion refused by the blood transfusion service?
 Yes No
14. Have you had an adverse reaction to either local or general anaesthetic?
 Yes No
15. Have you had a joint replacement?
 Yes No
16. Have you been hospitalised? If yes, what for and when?
 Yes No
17. Do you suffer from arthritis?
 Yes No
18. Do you suffer from allergic disorders such as hay fever or eczema?
 Yes No
19. Do you suffer from respiratory disease such as bronchitis or asthma?
 Yes No
20. Do you suffer from epilepsy, fainting attacks, giddiness or blackouts?
 Yes No
21. Do you have diabetes or does anyone in your family?
 Yes No
22. Do you bruise easily after a tooth extraction, surgery or injury or do you or your family have bleeding disorders? (If yes, please give details)
23. Do you carry a warning card?
 Yes No
24. Do you ever get cold sores?
 Yes No
25. Do you smoke?
 Yes No
26. Do you or any close relative suffer from CJD?
 Yes No
27. Is there any other relevant medical information the dentist should know about?

Completed by:

Patient

Guardian

Parent

Signature:

Date: