Please read and check your medical history. If there have been any changes please amend and circle Y (Yes)

Date .... Y / N Patient Sign .... Dentist Sign ....
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CR
CASSIO ROAD
DENTAL PRACTICE

CASSIO ROAD DENTAL MEDICAL HISTORY FORM

To obtain the best and safest treatment, our dentist needs to know of any problems which may affect your treatment.

NAME
TITLE .... FORENAME ....
SURNAME ....

ADDRESS ....
....
....

D.O.B. .... / .... / ....
SEX MALE / FEMALE

TELEPHONE NUMBERS
HOME ....
MOBILE ....
WORK ....
EMAIL ....

DOCTOR'S NAME ....
ADDRESS ....
.... TEL ....

ARE YOU:	**YES**	**NO**	**DETAILS**
Attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Are you an expectant or nursing mother?			
Taking any medicines from your doctor? (Tablets, creams, ointments, injection, contraceptive pill, other)			
Taking or have taken steroids in the last 2 years?			
Allergic to any medicines, foods, Materials?			
HAVE YOU:			
Had rheumatic fever or chorea (st vitus dance)?			
Had Jaundice, liver, kidney disease or hepatitis?			
Ever been told you have a heart murmur or heart problem, angina, blood pressure, heart attack?			
Had a bad reaction to a general or local Anaesthetic?			
Had a joint replacement?			
Have you ever been hospitalised? If so what for and when?			

DO YOU:	**YES**	**NO**	**DETAILS**
Have arthritis?			
Have a pacemaker, or have you had any form of heart surgery?			
Suffer from hay fever, eczema, asthma or any other allergies?			
Have fainting attacks, giddiness, blackouts or epilepsy?			
Have diabetes or does anyone in your family?			
Bruise easily, or following a tooth extraction, surgery or injury have you or your family bled so as to cause worry?			
Are you a smoker? If yes would you be interested in seeing a smoking cessation officer?			
How many units of alcohol do you consume per week? 1/2 pint beer/lager = 1 unit 1 small glass wine = 1 unit			
Do you carry a warning card?			
Please tick **OR TELL THE DENTIST** if you have any blood born viruses including H.I.V.			
Are there any other aspects concerning your health that you think your dentist should know about? (eg C.J.D.)			

Form completed by: Self / Parent / Guardian. Signature ....

Date ....