ARE YOU CURRENTLY

	Yes	No
Pregnant	☐	☐
Receiving treatment from a doctor, hospital or clinic?	☐	☐
Taking any prescribed medicines (eg. Tablets, ointments, injections or inhalers, including contraceptive pill and hormone replacement therapy)?	☐	☐
Carrying a medical warning card?	☐	☐

Please give details

DO YOU SUFFER FROM

	Yes	No
Allergies to any medicines (eg penicillin, substances (eg latex or rubber) or food?	☐	☐
Hay fever or eczema?	☐	☐
Bronchitis, asthma or other chest conditions?	☐	☐
Fainting attacks, giddiness, blackouts or epilepsy?	☐	☐
Heart problems, angina, blood pressure or stroke?	☐	☐
Diabetes (or does anyone in your family)	☐	☐
Arthritis?	☐	☐
Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐	☐
Any infectious diseases (including HIV and hepatitis)?	☐	☐
Do you get cold sore often?	☐	☐

Please give details

DO YOU, AS A CHILD OR SINCE, HAVE

	Yes	No
Rheumatic fever or chorea?	☐	☐
Liver diease (eg jaundice, hepatitis) or kidney disease?	☐	☐
Any other serious illness?	☐	☐

Please give details

DID YOU, AS A CHILD OR SINCE, HAVE

	Yes	No
Blood refused by the Blood Transfusion Service?	☐	☐
A bad reaction to general or local anaesthetic?	☐	☐
A joint replacement or other implant?	☐	☐
Treatment that required you to be hospitalised?	☐	☐
Heart surgery?	☐	☐
Brain surgery?	☐	☐
Growth hormone treatment before the mid-1980's?	☐	☐
A close relative with Creutzfeldt Jakob Disease (CJD)?	☐	☐

Please give details

DRINKING

How many units of alcohol do you drink per week?
(A unit is half a pint larger, a single measure of spirits or a single glass of wine / aperitif)

Units per day

SMOKING AND CHEWING

	Yes	No	In Past
Do you smoke any tobacco products now (or did you in the past) ?	☐	☐	☐
Do you chew tobacco, pan, use gutkha, or supari now (or did you in the past)?	☐	☐	☐

Times per day

Times per day

PLEASE GIVE DETAILS OF ANYTHING ELSE THE DENTIST MIGHT NEED TO KNOW ABOUT, SUCH AS SELF-PRESCRIBED MEDICINES (e.g. ASPRIN)

Emergency Contact No: