

## Wellmeadow Dental Practice: Patient Medical History Form

Surname

Tel. Home:

Forename:

Tel. Work:

D.O.B:

Mobile:

Address:

E-Mail Address:

Postcode:

	NO	IF YES, PLEASE GIVE DETAILS
<b>Are you:</b> Attending or receiving treatment from a doctor, Clinic or specialist?		
Taking medicines prescribed by your doctor? (please list below and what they are for).		
Taking bisphosphonates/alendronic acid or have ever taken them? (This medication may be used for cancer patients or osteoporosis patients)		
Allergic to any medicines or materials?		
<b>Have you had:</b> Jaundice, liver or kidney disease?		
Or ever been told you have A Heart Murmur?		
Angina?		
High or Low Blood Pressure?		
Heart Disease?		
A Pacemaker?		
A bad reaction to local anaesthetic?		
HIV, HEP B or HEP C?		
<b>Do you:</b> Have arthritis, if so what type and where?		
Suffer from bronchitis, asthma or other chest condition?		
Have fainting attacks, giddiness, blackouts or epilepsy?		
Have diabetes?		
Bruise easily or suffer prolonged bleeding?		
Carry a warning card?		
Smoke? (number per day)		
Drink alcohol? (number of units per week)		
Have any other medical conditions? (please specify)		

**Doctor's Details****Name:****Telephone Number:****Address:****Name of medicine:****What is it used for? :**

*****	*****
*****	*****
Completed by: self / guardian	
Signature:	
Date:	