DOVE DENTAL CARE

PATIENT CONFIDENTIAL MEDICAL HISTORY

TITLE:	**FIRST NAME/S:**	**SURNAME:**
DATE OF BIRTH:	**MALE/FEMALE**	
ADDRESS:		
POSTCODE:	**EMAIL ADDRESS:**	
MOBILE TELEPHONE NO:	**HOME TELEPHONE NO:**	
OCCUPATION:	**WORK TELEPHONE NO:**	
DOCTOR'S NAME AND ADDRESS:		

PLEASE TICK YES OR NO TO THE FOLLOWING QUESTIONS

	YES	NO	DETAILS
HAVE YOU EVER HAD RHEUMATIC FEVER OR CHOREA (ST VITUS' DANCE)?			
DO YOU SUFFER FROM ANY INFECTIOUS DISEASES (INCLUDING HEPATITIS OR HIV)?			
DO YOU HAVE HEART TROUBLE, A HEART MURMUR, OR HIGH BLOOD PRESSURE?			
DO YOU HAVE ANY CHEST TROUBLE, INCLUDING INFECTION EG. TUBERCULOSIS?			
HAVE YOU HAD JAUNDICE OR HEPATITIS?			
HAVE YOU EVER HAD SEVERE BLEEDING THAT REQUIRED SPECIAL TREATMENT (SUCH AS HOSPITAL ADMISSION OR BLOOD TRANSFUSIONS) AFTER EXTRACTIONS, SURGERY OR INJURY?			
IS THERE A HISTORY OF SEVERE BLEEDING IN YOUR FAMILY?			
HAVE YOU EVER HAD ANY BLOOD TESTS?			
ARE YOU TAKING ANY TABLETS, MEDICINES, OINTMENT OR OTHER DRUGS?			
ARE YOU ALLERGIC TO PENICILLIN OR ANY OTHER DRUG OR SUBSTANCE?			
ARE YOU ATTENDING OR RECEIVING TREATMENT FROM A DOCTOR, HOSPITAL OR CLINIC?			
HAVE YOU HAD ANY SERIOUS OPERATIONS OR ILLNESSES?			
ARE YOU TAKING OR HAVE YOU TAKEN STEROIDS IN THE LAST TWO YEARS?			
DO YOU SUFFER FROM ASTHMA, HAY FEVER, OR ECZEMA?			
HAVE YOU EVER HAD A BAD REACTION TO A GENERAL OR LOCAL ANAESTHETIC?			
DO YOU HAVE FAINTING ATTACKS, BLACKOUTS, GIDDINESS OR EPILEPSY?			
ARE YOU A DIABETIC?			
DO YOU SMOKE ANY TOBACCO PRODUCTS NOW (OR DID YOU IN THE PAST)? IF YES HOW MANY TIMES PER DAY?			
ARE YOU PREGNANT?			

How did you hear about our practice? ***(Or is it over 2 years)?*** _____

If you were personally recommended whom by? _____

PLEASE ADD ANY FURTHER INFORMATION CONCERNING YOUR HEALTH THAT YOU FEEL THE DENTIST SHOULD KNOW _____

PATIENT SIGNATURE _____ **DATE** _____
(Or Parent/Guardian if under 16 years of age)