Medical History update:

Please check your details overleaf and inform us of any changes

Patients signature:…… Date……

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Smile dental care

Please take a few minutes to fill out this form so we can better assist you with your dental needs.

Surname (Mr/Mrs/Miss/Ms)……

Forename……

Address……

……

Postcode……

Tel (home)…… Tel (work)……

Tel (mob)……

Date of Birth……Occupation……

Email Address……

For data protection regulations, can appointments be disclosed, made or cancelled by a member of your family/third party? YES NO

Do you smoke? YES NO

How did you hear about our practice?……

Name, address and phone number of your Doctor:……

……

If you are not sure of any of the questions, or if your medical circumstances change, please inform the Dental Surgeon

Signature of patient/parent/guardian:…… Date……

Please complete this form by ticking the appropriate boxes and answering the questions
All details will be strictly confidential

Do you have or have you ever suffered from:	yes	no
Rheumatic fever?	☐	☐
Any heart complaint, heart surgery or stroke?	☐	☐
Diabetes?	☐	☐
Epilepsy or fainting attacks?	☐	☐
Chronic bronchitis or asthma?	☐	☐
Hepatitis?	☐	☐
Excessive bleeding?	☐	☐
High blood pressure?	☐	☐
Any other serious illness?	☐	☐
Do you carry a medical warning card?	☐	☐
Are you at present taking any medicine or tablets Please give details in the box opposite	☐	☐
Are you allergic to any medicine, substances or latex? Please give details in the box opposite	☐	☐
Are you pregnant	☐	☐
In the past 2 years have you undergone any operations?	☐	☐
been treated with hydro-cortisone or corticosteroids?	☐	☐
Have you ever had a joint replacement operation?	☐	☐
Please tick or tell the dentist if you are HIV positive	☐	☐

If 'yes' to any questions please give details in the box opposite

Are you at present taking any medicine or tablets?
Please list these below

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For patients under 18

Name of Parent or guardian……

Name of school or college……