Southfields
DENTAL CENTRE ... at the blue house

Patient Medical Form

We ask you for information about your general health to help us treat you safely. Please complete your contact details, answer the health questions and then sign the form. We will use this form at later visits to discuss any changes in your general health. All information will be kept strictly confidential by the people caring for you. None of your replies to the questionnaire will prevent you having treatment here.

Title First Name Surname

Date of Birth Male/Female Date of last dental treatment

Address Postcode

Preferred Contact Method: Home ☐ Mobile ☐ Work ☐ Letter ☐ Email ☐

Telephone: Home Work Mobile

Occupation Email address:

Doctors Details: Name Contact Number

Address

ARE YOU CURRENTLY:	YES	NO	DETAILS
1. Receiving treatment from a doctor, hospital or clinic?			
2. Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?			
3. Carrying a medical warning card?			
4. Pregnant			

DO YOU SUFFER FROM:			
5. Allergies to any medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods?			
6. Hay fever or eczema?			
7. Bronchitis, asthma or other chest condition?			
8. Fainting attacks, giddiness, blackouts, epilepsy?			
9. Heart problems, angina, blood pressure problems, or stroke?			
10. Diabetes (or does anyone in your family)?			
11. Arthritis?			
12. Bruising or persistent bleeding following injury, tooth extraction or surgery?			
13. Any infectious diseases (including HIV and hepatitis)?			

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Patient Medical Form

continued

HAVE YOU EVER HAD:
14. Rheumatic fever or chorea?
15. Liver disease (e.g. jaundice, hepatitis) or kidney disease?
16. Any other serious illness? ☐ ☐ ☐ ☐ ☐
17. Blood refused by the Blood Transfusion Service?
18. A bad reaction to general or local anesthetic?
19. A joint replacement or other implant?
20. Treatment that required you to be in the hospital?
21. Heart surgery?

DRINKING
22. How many units of alcohol do you drink per week? (1 unit is half a pint of lager, a single measure or a single glass of wine/aperitif

SMOKING AND CHEWING	YES	NO	PAST QUANTITY
23. Do you smoke any tobacco products now (or in the past)?			
24. Do you chew tobacco, pan, use gutkha or supari now (or in the past)? Please give any other details which your dentist might need to know about, such as self-prescribed medicines (e.g. aspirin)			

Completed by (please tick) Self ☐ Parent ☐ Guardian ☐

Signature

For dentists use only:

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

Date	No Change	Change	Patients Signature

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