WESTON PARK Dental

CONFIDENTIAL MEDICAL HISTORY

Title ______________________ Occupation ______________________

Name ______________________ Email ______________________

Date of birth ______________________ Tel. Home/Work ______________________

Address ______________________ Mobile Tel ______________________

Doctor's details ______________________

Do you suffer from or have you ever experienced any of the following:

	YES	NO
Endocarditis	☐	☐
Rheumatic Fever	☐	☐
Heart Disease / Heart Valve Surgery	☐	☐
Heart Murmurs	☐	☐
High / Low Blood Pressure	☐	☐
Bruising / Prolonged Bleeding	☐	☐
Diabetes	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Tuberculosis (or have you recently been in contact with someone who has)	☐	☐
Hepatitis / HIV	☐	☐
Epilepsy / Fainting	☐	☐
Allergy to Penicillin / Aspirin / Latex	☐	☐
Have you had any operations or a serious illness in the last 3 years?	☐	☐
Are you taking or have you taken steroids in the last 2 years?	☐	☐
Do you take any medication for osteoporosis (e.g. bisphosphonates)?	☐	☐
Are you taking any other medication at present?	☐	☐
Are you pregnant or a nursing mother?	☐	☐
Do you suffer from dry mouth?	☐	☐
Do you smoke / chew tobacco or have you done so within the last 5 years?	☐	☐
Do you drink more than 21 units (male) / 14 units (female) of alcohol per week?	☐	☐
Do you have acidic or fizzy drinks more than 3 times a day?	☐	☐
Do you have sugary foods between main meals?	☐	☐
Is there a family history of gum disease?	☐	☐
Do your gums bleed when you brush your teeth?	☐	☐
Do you have sensitive teeth?	☐	☐
Do you clench / grind your teeth?	☐	☐
Does your jaw click?	☐	☐
Do you use herbal / fluoride FREE toothpaste?	☐	☐

If you have answered YES to any of the above, please give details:

I confirm details of my medical history to be correct

Signed ______________________ *Date* ______________________