Dentaliving Medical History

Patient Details	
Full Name	
DOB	
Address	
Mobile No.	
Email Address	

Are you taking any prescribed medication?

- ☐ Yes
- ☐ No

If yes please provide list here

Are you pregnant or had a baby in the last 12 months?

- ☐ Yes
- ☐ No
- ☐ N/A

Have you ever suffered from Bronchitis, Asthma or other chest condition?

- ☐ Yes
- ☐ No

Have you ever suffered from Fainting attacks, giddiness, blackouts, epilepsy?

- ☐ Yes
- ☐ No

Have you ever suffered from Heart problems, angina, blood pressure problems or stroke?

- ☐ Yes
- ☐ No

Have you ever suffered from diabetes?

- ☐ Yes
- ☐ No

Have you ever suffered from bruising or persistent bleeding following injury, tooth extraction or surgery?

- ☐ Yes
- ☐ No

Have you ever suffered from liver disease (e.g jaundice, hepatitis) or kidney disease?

- ☐ Yes
- ☐ No

Have you ever suffered from any other serious illness or infectious disease?

- ☐ Yes
- ☐ No

How many units of alcohol do you drink per week? (A unit is half a pint of lager, a single measure of spirits or a single glass of wine)

- ☐ Yes
- ☐ No

Specify Units……

Do you smoke any tobacco products? (Times per day)

- ☐ No
- ☐ Yes, less than 10 cigarettes a day
- ☐ Yes, more than 10 cigarettes a day

Are you allergic to any of the antibiotics listed below?

- ☐ Penicillin V
- ☐ Amoxicillin
- ☐ Metronidazole
- ☐ Erythromycin
- ☐ Clindamycin

Are you allergic to any analgesics?

- ☐ Yes
- ☐ No

Is there any relevant medical history that you wish to inform us of?.....
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Sign Digitally:	
Date:	