CATHERINE COURT

DENTISTRY

MEDICAL HISTORY FORM

Name:			
Date of Birth:	**Sex: Male/Female**		
Address:			
Telephone Home:	**Mobile:**		
Occupation:			
How long since last dental treatment:			
Doctors Name & Address:			
Are you	**YES**	**NO**	**Details**
An Expectant mother			
Receiving medical treatment			
Taking any medication			
Taking or have taken steroids in the past 2 years			
Allergic to any medicines, food or materials			
Have you **Had rheumatic fever or chorea (St Vitus Dance)**			
Had jaundice, liver, kidney disease or hepatitis			
Had any Heart problems, a heart murmur, angina or a heart attack			
High blood pressure			
Blood tests, inoculations etc			
Ever had a blood donation refused by the Blood Transfusion service			
Adverse reaction to either local anesthetic or general anesthetic			
Had a joint replacement			

Been Hospitalized if "Yes", What for and when			
Do You **Suffer from Arthritis**			
Have a pace maker, or had any form of heart surgery			
Suffer from allergic disorders such as hay fever or eczema			
Suffer from respiratory disease such as Bronchitis or Asthma			
Have Epilepsy, Fainting attacks, giddiness or blackouts			
Have Diabetes or does anyone in your family			
Bruise easily following a tooth extraction, surgery or injury or do you or your family have bleeding disorders			
Carry a medical warning card			
Ever get cold sores			
Do you smoke			
Do you or any close relatives suffer from CJD			
Is there any other relevant medical information that the dentist should know about			

Completed by: Self/Patient/Guardian. **Signature**……

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