Market Place Dentistry Medical History Form

Please complete one copy per patient

Name	Doctor's Name
Date of Birth	Doctor's Practice
Address	
Mobile No.	Who to contact in case of a medical emergency (Please provide name & phone number):
Landline	
Email	

Are you currently:	**Y**	**N**	**Further Details**
Receiving any treatment from a doctor, hospital or clinic?			
Taking any prescribed medications, including tablets, inhalers, injections, creams?			If yes, please list here:
Receiving, or recently completed, treatment for cancer?			
Carrying a medical warning card?			
Pregnant or possibly pregnant?			Due Date:
Allergic to anything?			Please list:

Have you ever had:	**Y**	**N**	**Further Details**
A bad reaction to general or local anaesthetic?			
Heart surgery?			
Notification you may be at risk of variant Creutzfeldt-Jakob disease?			
Cold sores?			

Do you have, or receive treatment for:	**Y**	**N**	**Do you have, or receive treatment for:**	**Y**	**N**
Angina?			Diabetes?		
High blood pressure?			Liver disease, including hepatitis?		
Heart failure?			Kidney disease or transplantation?		
Prosthetic heart valves?			HIV?		
A pacemaker or internal defibrillator?			Fainting, giddiness, epilepsy or blackouts?		
Other heart problems?			Bone or joint disease, including osteoporosis?		
Learning difficulties?			TB or other infectious respiratory diseases?		
Mental health problems?			Asthma, bronchitis, legionella or other non-contagious respiratory problems?		
Easy bruising?					
Persistent bleeding following injury, tooth extraction or surgery?			Any other serious or infectious diseases or medical conditions?		

If yes to any of the above, please give details:

Is there anything else your dentist may need to know about you such as self-prescribed medication, lack of mobility, deafness, etc?	

Social History:	
How many units of alcohol do you consume in an average week? (1 pint of strong beer = 3 units, 1 large glass of wine = 3 units, 25ml of spirits = 1 unit)	
Have you smoked regularly in the past? If so, when did you stop?	
Do you currently smoke? If so, how many per day?	
Do you chew tobacco, guthka, supari or pan now or in the past?	

Completed by (please circle): Self Parent Guardian Other…………………………………

Sign.. Date............................