Medical History Form

El-Nashar
DENTAL CARE

Name:.....

Date of Birth:.....

Telephone: Home:.....
Mobile:.....
Work:.....

Doctor's name and address:.....
.....
.....

Doctor's telephone:.....

1. Are you pregnant?.....
2. Are you currently receiving treatment from a doctor, hospital or clinic? .....
   .....
3. Are you currently taking any prescribed medicines (e.g. tablets, ointments or inhalers, including contraceptives and hormone replacement therapy)?.....
   .....
4. Are you carrying a medical warning card?.....
5. Do you suffer from allergies to any medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods?
   .....
6. Do you suffer from hay-fever or eczema?.....
7. Do you suffer from bronchitis, asthma or other chest conditions?.....
   .....
8. Do you suffer from fainting attacks, giddiness, blackouts or epilepsy? .....
   .....
9. Do you suffer from heart problems, angina, blood pressure problems or strokes?.....
   .....
10. Are you diabetic (or is anyone in your family)? .....
11. Do you suffer from arthritis? .....
12. Do you suffer from bruising or persistent bleeding following injury, tooth extraction or surgery?....
    .....
13. Do you suffer from any infectious diseases (including HIV and hepatitis)? .....

14. Have you ever had rheumatic fever or chorea? .....
15. Have you ever had liver disease (e.g. jaundice, hepatitis) or kidney disease? .....
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16. Have you ever had any other serious illness? .....
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17. Have you ever had blood refused from the Blood Transfusion Service? .....
18. Have you ever had a bad reaction to general or local anaesthetic? .....
19. Have you ever had a joint replacement or any other implant? .....
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20. Have you ever had treatment that required you to be in hospital? .....
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21. Have you ever had heart or brain surgery? .....
22. Did you receive growth hormone treatment before the mid 1980s? .....
23. Do you have any close relatives (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob disease? .....
24. Do you regularly drink more than 14 units of alcohol per week? .....
25. Do you smoke any tobacco products now (or did you in the past)? .....
26. Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)? .....
27. Is there any other information which your dentist might need to know about, such as self-prescribed medicines (e.g. aspirin)? .....
28. Please list all medications currently being taken: .....
.....

Signature of patient: ..... Date: .....

Medical history update:

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	List any changes below	Patient's initials