Green Park Dental Practice

PATIENT MEDICAL HISTORY

Patient Name:	Date of Birth:	Occupation:
Address	Home No: Mobile No: Email:	Preferred method of contact:

Doctors Name & Address……

Last visit to a dental practice:……

On a scale of 1 to 5, how nervous are you regarding treatment? Not at all 1 2 3 4 5 Very Anxious

YES	NO	QUESTIONS
		Are you currently pregnant?
		Are you currently receiving treatment from a doctor, hospital or clinic?
		Are you currently taking any prescribed medicines (eg: tablets, inhalers, including contraceptives and hormone replacement therapy)?
		Are you carrying a medical warning card?
		Do you suffer any allergies to medicines (eg penicillin), substances (eg latex/rubber) or foods?
		Do you have a pacemaker?
		Do you suffer from hayfever or eczema?
		Do you suffer from bronchitis, asthma or other chest conditions?
		Do you suffer from fainting attacks, giddiness, blackouts or epilepsy?
		Do you suffer from heart problems, angina, blood pressure problems or stroke?
		Are you a diabetic (or is anyone in your family)?
		Do you suffer from arthritis?
		Do you suffer from bruising or persistent bleeding following injury, tooth extraction or surgery?
		Do you suffer from any infectious diseases (including HIV and Hepatitis)?
		Have you ever had rheumatic fever or chorea?
		Have you ever had liver disease (eg jaundice, hepatitis) or kidney disease?
		Have you ever had any other serious illness?
		Have you ever been refused by the Blood Transfusion Service?
		Have you ever had a reaction to a General or Local Anaesthetic?
		Have you ever had a joint replacement or any other implant?
		Have you ever had treatment that required you to be in hospital?
		Have you ever had heart surgery?
		Have you ever had brain surgery?
		Do you suffer from Osteoporosis OR are you taking or have taken Bisphosphonates e.g. Alendronic Acid?
		Do you have any close relatives (parents, sibling, child, grandparent/child) with Creutzfeldt Jacob Disease?
		Do you drink alcohol? If yes, on average how many units per week…….
		Do you smoke or use tobacco/nicotine products now (or did you in the past)?
		Do you suffer or have you suffered from cold sores?
		Is there any other information which your dentists might need to know about, such as self-prescribed medicines (eg Aspirin)?

If you have answered **YES** to any of the above questions, please give details below.

List of Medications and any other information:

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At Green Park Dental Practice we take great care with all the personal data we hold, to ensure that we comply with best professional practice and with the law. For a full copy of our Data Privacy Policy, please ask at reception.

(Please circle)

If you require a referral outside of the practice (specialists, hospitals, GP's or dental laboratories) to ensure your best possible care, may we share your personal data?
This **will not** be used for any marketing purposes. YES/NO

Do you consent for us to contact you by phone/text/email and letter? YES/NO
(preferred contact……)

Are you happy for us to leave messages for you (answerphone)? YES/NO

Are you happy for another person to make or change appointments for you? YES/NO

Signature:…….. Date:…….

Date	Updated	Patient Signature	Clinician Signature