Wickham Market Dental Practice - Medical History Form

Full Name:
Date of birth:
Home Address:

Doctors name/address:

Are you?	Yes	No	Please provide as much detail as possible if you tick 'yes'
Attending or receiving treatment from a doctor, hospital or specialist?			
Taking any medication Please list on the back of this form or provide a copy of your prescription.			

Do you suffer from?	Yes	No	Please provide as much detail as possible if you tick 'yes'
Allergies to any medicines e.g. penicillin			
Asthma?			
Bronchitis, emphysema, COPD other chest / lung condition?			
Hayfever or eczema?			
Fainting, blackouts, epilepsy?			
Heart conditions, angina, stroke? Heart surgery?			
Diabetes?			
Blood Pressure?			
Arthritis or other bone/ joint disease?			
Thyroid Problems?			
Liver or Kidney Disease?			
Any infectious diseases (e.g HIV, Hepatitis B,)			
A bad reaction to Local or General Anaesthetic?			
Are you an expectant or nursing mother?			

Name _____ Signature _____ Date _____