clover house dental practice

Medical / Dental History

Surname:	Title:
Forenames:	Date of birth:
Address: Postcode: Occupation:	
Telephone: Mobile:	
Email address:	
Doctors name and address:	
Are you attending OR currently receiving treatment from a doctor, hospital, clinic or specialist? YES / NO	
Are you taking any medicines (e.g. tablets, injections, inhalers, contraceptives or hormone / replacement therapy?) YES / NO Details:	
Are you taking or have you taken steroids in the last 2 years? YES / NO	Are you allergic to any medicines / food / materials? YES / NO Details:
Are you pregnant or breast feeding? YES / NO Due date / Birth date:	

Have you, as a child or since:	*Yes*	*No*	*If yes, please give details*
Had Rheumatic fever?			
Had Jaundice, liver or kidney disease, HIV or Hepatitis?			
Been told you have high blood pressure or a heart problem, or had a heart attack, stroke or pacemaker?			
Ever had your blood refused by the transfusion service?			
Had a bad reaction to a local or general anaesthetic?			
Do you:	*Yes*	*No*	*If yes, please give details*
Suffer from bronchitis, asthma or any other chest conditions?			
Have fainting attacks, blackouts or epilepsy?			
Have diabetes, or does anyone in your family?			
Bruise easily or bleed profusely following tooth extraction, surgery or injury?			
Carry a warning card?			
Smoke? If so, how many?			
How many units of alcohol do you drink per week?			
Are there any other aspects concerning your health that you think your dentist should know?			

Have you any concerns about your dental health?
Are you happy with your overall appearance of your smile? Is there any aspect you would like to change?
Are there any other aspects of your facial appearance you would like to improve? E.g. wrinkles, lines, lips, cheeks
How did you hear about us?

Signature: Date: