

## Watford Dental Practice: Medical History Form

<b>Name:</b>			
<b>Date of Birth:</b>			
<b>Address :</b>			
<b>Telephone Numbers</b>	<b>Home:</b>	<b>Mobile:</b>	<b>Are you happy to be contacted by mobile or text (GDPR)?</b> YES or NO (please circle)
<b>Email Address:</b>		<b>Are you exempt from NHS charges?    Yes    No</b> <b><u>IF YES, PLEASE DO LET RECEPTION KNOW</u></b>	
<b>Occupation:</b>		<b>When did you last see a dentist?</b>	
<b>Doctors Details:</b>			
<b>DO YOU SUFFER FROM? If yes please circle the condition</b>			<b>TICK</b>
			<b>YES    NO</b>
Allergies to any medication eg: (penicillin)			
Substances eg: (latex/ rubber or food)			
A heart murmur or heart problems, angina, blood pressure problems, or stroke			
Diabetes			
Fainting attacks, Giddiness, Blackouts, Epilepsy			
Bronchitis, Asthma or any other chest conditions			
Infectious disease including HIV/AIDS			
Arthritis, Bone or joint disease			
Bruising or persistent bleeding following tooth extraction or surgery			
<b>HAVE YOU EVER HAD? If yes please circle the condition</b>			
Rheumatic fever or Chorea, Liver disease, Jaundice, Hepatitis, Kidney disease			
Any other serious illness			
<b>HAVE YOU EVER HAD?</b>			
Bad reaction to Local or General anaesthetic			
Joint replacement or other implant			
A pacemaker or any form of heart surgery			
<b>ARE YOU CURRENTLY?</b>			
Pregnant			
Carrying a warning card			
Taking any medication? If yes, please hand in your repeated prescription			
Have you been prescribed Bisphosphonate treatment either tablet or injection			
Do you smoke any tobacco products? If yes, how many per day			
Do you chew tobacco pan, use gutkha or supari			
<b>SMOKERS – are you interested in receiving smoking cessation advice?</b>			
Do you drink alcohol? If yes, how many units per week			
Glass of wine 125ml-1.7 units 175ml – 2.3 units			
Can of beer 440ml – 1.8 units    Pint 568ml 2.3 units			
<b>DO YOU CONSIDER YOURSELF TO HAVE ANY DISABILITY?</b>			
<b>Signed by:</b>	Patient / Parent / Guardian / Other (Please State)		
<b>Patient:</b>		<b>Date:</b>	
<b>Dentist</b>		<b>Date:</b>	

**PLEASE SIGN IF YOU READ AND FULLY UNDERSTOOD OUR CANCELLATION AND NON-ATTENDANCE POLICY! (SEE ATTACHED)**

**FOR FURTHER INFORMATION ON DATA PROTECTION 2018 (GDPR) ASK TO SEE OUR PRIVACY NOTICE.**