Confidential Medical History

Doctor's surgery ____

Are you under medical care or taking any prescribed or self-prescribed medication? ☐ Yes ☐ No

Please list any medications here.

Have you been prescribed Steroids in the last year? ☐ Yes ☐ No

Have you ever been prescribed Bisphosphonates (*bone strengthening drugs*) **Orally or intravenously?** ☐ Yes ☐ No

Do you have any Allergies? If so, please specify. ____________________________ ☐ Yes ☐ No

Do you have a DNR or ADRT? If so, please provide a copy ☐ Yes ☐ No

Have you had any of the following? (Please✓ all that apply) ***Please give details***

- ☐ Joint replacement or other implant ______________________________________
- ☐ Congenital heart lesion/pacemaker ______________________________________
- ☐ Jaundice, hepatitis, liver, kidney disease ______________________________________
- ☐ Heart condition/angina ______________________________________
- ☐ Infectious diseases ______________________________________
- ☐ High or low blood pressure or Stroke ______________________________________
- ☐ Bronchitis, asthma, chest conditions ______________________________________
- ☐ Prolonged bleeding/bruising problems ______________________________________
- ☐ Diabetes ______________________________________
- ☐ A medical warning card ______________________________________
- ☐ Epilepsy fits, fainting attacks ______________________________________
- ☐ Arthritis ______________________________________
- ☐ Hay Fever or Eczema ______________________________________
- ☐ Any other serious illness ______________________________________
- ☐ Blood refused when tried to donate ______________________________________

Have you had any ill effects from any of the following? ***(Please ✓ all that apply)***

☐ Antibiotics ☐ Local or general anaesthetic ☐ Dental treatment

☐ Do you think you *may* be pregnant? If so when is the expected delivery date? ________________

☐ Do you have problems lying flat?

☐ Have you ever had an operation? (Please specify)____________________________

☐ Have you ever had a close relative with CJD? (Please specify)____________________________

Do you smoke? ☐ Yes ☐ No If yes, how many: a day? ____________________________

Do you Vape? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, how many units a week? ________________________

Completed by ☐ Self ☐ Parent ☐ Guardian

Signature (Patient)	Date	Signature (Dentist)	Date