ILFRACOMBE DENTAL PRACTICE

Medical History Form

	Yes	No	Details
Are you receiving treatment from a doctor, hospital or clinic?			
Are you taking any prescribed medicines?			
Do you carry a medical warning card?			
Are you pregnant?			
Do you have any allergies to any medicines, substances or food?			
Do you suffer from; bronchitis, asthma, or other chest condition?			
Do you suffer from; fainting attacks, giddiness, blackouts, epilepsy?			
Do you suffer from; heart problems, angina, blood pressure problems, or stroke?			
Do you suffer from; diabetes (or does anybody in your family)?			
Do you suffer from; bone or joint disease, joint replacement or other implant?			
Do you suffer from; bruising or persistent bleeding following injury, tooth extraction or surgery?			
Do you suffer from; liver disease or kidney disease?			
Do you have any other serious illness?			
Have you ever had your blood refused by a Blood Transfusion Service?			

Have you ever had a bad reaction to general or local anaesthetic?			
Treatment that required you to be in hospital?			
Have you ever had heart surgery?			
Do you regularly drink alcohol, if so what is your average weekly consumption?			
Do you smoke tobacco products now (or in the past)?			
Do you chew tobacco, pan, use gutkha, or supari now (or in the past)?			
Do you have any infectious diseases?			
Do you have rheumatic fever or chorea?			
Do you suffer from hay fever or eczema?			
Do you have arthritis?			