Patient Medical History Form
Strictly Confidential

Premier Dental Clinic

The Medical History is very important to help us trat you correctly

Please write all details in **BLOCK CAPITALS.**

First Name

M/F

Last Name

Address

Date of Birth

dd/mm/yyyy

Contact Telephone N°

daytime

Occupation

mobile

Doctor's Name, Address and Telephone N°

Email Address

ARE YOU

	Y	N	Details
Attending or receiving treatment from a Doctor, Hospital or Clinic?	☐	☐	
Taking any medicines from your Doctor (tablets, creams, injections etc)? Taking or have taken any steroids in the last 2 years?	☐	☐	
Taking warfarin or a blood thinning medication? Pregnant?	☐	☐	
Allergic to any medicines, food or materials?	☐	☐	

HAVE YOU

Had rheumatic fever or cholera (ST VITUS DANCE)?	☐	☐	
Had jaundice, liver, kidney disease or hepatitis?	☐	☐	
Ever been told you have a heart murmur, heart problems, angina, blood pressure or heart attack?	☐	☐	
Had any blood tests, inoculations in the past year?	☐	☐	
Had your blood refused by the blood transfusion service?	☐	☐	
Had a bad reaction to general or local anaesthetic?	☐	☐	
Had a joint replacement?	☐	☐	
Been hospitalised? If YES, what for and when?	☐	☐	

DO YOU

Have arthritis?	☐	☐	
Have a pacemaker, or any form of heart surgery?	☐	☐	
Suffer from hay fever, eczema or any other allergy?	☐	☐	
Suffer from bronchitis, asthma or any other chest conditions?	☐	☐	
Have fainting attacks, giddiness, blackouts or epilepsy?	☐	☐	
Have diabetes or does anyone in your family?	☐	☐	
Bruise easily or following a tooth extraction, surgery or injury, have you or your family bled so as to cause you to be worried, bleeding disorders?	☐	☐	
Carry a warning card?	☐	☐	
Ever get cold sores?	☐	☐	
Smoke (or have you done so in the past)? If so how many a day/week?	☐	☐	
Drink alcohol? If YES, how many units per week do you consume?	☐	☐	
Chew tobacco pan or use supari currently (or have done so in the past)?	☐	☐	
Have or are you being treated for Cancer	☐	☐	
Have or are you being treated forHIV/AIDS?	☐	☐	
Suffer from any infectious diseases including tuberculosis?	☐	☐	

Any other relevant imformation your Dentist should know about?

☐ Patient
☐ Parent
☐ Guardian

Signature

Date

dd/mm/yyyy