Farlington Dental Practice
Confidential medical and dental history information form

Welcome to Farlington Dental practice to enable us to treat you safely please spare a few moments to complete the health questions. We will use this form at later visits to discuss any change in your general health. All information will be kept strictly confidential by the people caring for you.

Title Mr □ Mrs □ Miss □ Ms □
Surname…………………………………………………………..

First Name(s)……………………………………………………..

Date of Birth……………..

Address…………………………………………………………………………………….................
Post Code………………...

Please let us know if we are allowed to contact you by mobile or email
(Mobile)…………………………………………
(home)……………………………………………
(work)…………………………………………..

Email Address:…………………………………………………………………...

Occupation:………………………………………………………………………

Doctors name………………………

Address……………………………………………………………………………………………
……………………………………………………………..
Number…………………………......

NEXT OF KIN: Name: …………………………… Contact Number:……………………………

When was your last visit to the Dentist ------------------

WE REQUIRE A LIST OF MEDICATIONs &/ REPEATED PRESCRIPTIONs on your visits

Please answer the questions carefully as certain medical conditions can effect treatment	**Yes/No**
Are you currently receiving treatment from a doctor, hospital or clinic? If yes please give details:	
Are you currently taking any prescribed medicines (eg tablets, ointments, or inhalers, including contraceptives and hormone replacement therapy? If yes please give details:	
Are you pregnant?	
Are you carrying a medical warning card? If yes please give details:	
Do you suffer from allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods? If yes please give details:	
Do you suffer from Hay fever or eczema? If yes please give details:	
Do you suffer from fainting attacks, giddiness, blackouts or epilepsy If yes	

please give details?	
Do you suffer from heart problems, angina, blood pressure or stroke? If yes please give details:	
Are you diabetic (or is anyone in your family)? If yes please give details:	
Do you suffer from arthritis?	
Do you suffer from bruising or persistent bleeding following injury tooth extraction or surgery? If yes please give details:	
Do you suffer from any infectious diseases (including HIV Hepatitis or other? If yes please give details:	
Have you ever had any other serious illness? If yes please give details:	
Have you ever had blood refused by the Blood Transfusion Service? If yes please give details:	
Have you ever had a bad reaction to general or local anaesthetic? If yes please give details:	
Have you ever had a joint replacement or other? If yes please give details:	
Have you ever had treatment that required you to be in hospital? If yes please give details:	
Have you ever had heart surgery? If yes please give details:	
Have you ever had brain surgery? If yes please give details:	
In the past two years, have you ever undergone any operation? If yes please give details:	
Did you receive growth hormone treatment before the mid 1980's?	
Do you have any close relatives (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jacob disease (CJD)?	
Do you regularly consume more than 21 units of alcohol in a week?	
Do you smoke any tobacco products(or did you in the past)? If yes please give details:	
Do you chew tobacco, pan, use gutkha or supari(or did you in the past)? If yes please give details:	
Is there any other information your dentist might need to know about, such as self-prescribed medicines (e.g. aspirin)? If yes please give details:	
Does anything concern you about your dental health at the moment?	
Are you happy with the appearance of your teeth and gums?	

I confirm that I have answered the above questions accurately to the best of my knowledge and wish to be registered at Farlington Dental Surgery.

Signed…………………………………….....Self/Parent/Guardian