MONKSTOWN DENTAL

NEVER STOP SMILING

confidential medical history

To offer the best and most appropriate dental care, please provide us with as much detail as possible about your medical history.

Please complete all questions.

How did you hear about the practice? ☐ Friend/Family ☐ Referral Card ☐ Internet/Website

If other please can you tell us

Title: _____ Full Name: _____

Date of Birth: _____

Address: _____

_____

Postcode: _____ Home No: _____

Mobile No: _____ Work No: _____

Email: _____

Occupation: _____

Name and address of your doctor: _____

_____

_____

Are you:	**Circle**	**Details**
Receiving treatment from your doctor or hospital?	Yes/No	
Taking any medication? (e.g. tablets, ointments, inhalers - including contraceptives and hormone replacement therapy)	Yes/No	

Please list medication below:

_____

_____

_____

_____

_____

_____

Have you:	**Circle**	**Details**
any allergies (eg penicillin, substances (eg latex, rubber) or foods?	Yes/No	
heart problems, heart surgery, angina, blood pressure problems, or stroke?	Yes/No	
had rheumatic fever or chorea?	Yes/No	
had liver disease (eg jaundice, hepatitis) or kidney disease?	Yes/No	
asthma, bronchitis, or other chest conditions?	Yes/No	
ever had blood refused from the Blood Transfusion Service?	Yes/No	
ever had a bad reaction to general or local anaesthetic?	Yes/No	
any close relative (parent, sibling, child, grandparent or grandchild) with Creautzfeldt Jakob disease (C.J.D.)?	Yes/No	
arthritis?	Yes/No	
a joint replacement or other implant?	Yes/No	
any other serious illness?	Yes/No	
are you an expectant mother?	Yes/No	

Do you:	**Circle**	**Details**
experience fainting attacks, giddiness, blackouts or epilepsy?	Yes/No	
carrying a medical warning card?	Yes/No	
bruise or bleed excessively following injury, tooth extraction or surgery?	Yes/No	
smoke any tobacco products now (or did you in the past)?	Yes/No	
regularly drink more than 21 units of alcohol per week?	Yes/No	
suffer from infectious diseases (including HIV and hepatitis)?	Yes/No	
are you diabetic (or is anyone in your family)?	Yes/No	
is there any other information which your dentist might need to know about, such as self-prescribed medicines (eg aspirin)?	Yes/No	
take any steroids or receiving any treatment for cancer (chemo/radio) or osteoporosis	Yes/No	

Signature _____ Date _____