GLADE
DENTAL PRACTICE

Medical History

Forename:	Surname:
Date of Birth:	Gender: (Please circle) Male / Female
Telephone Number:	
Email Address:	
Address:	
GP Details:	

Are you currently taking any medication? (If yes, please detail below)		
Do you have / have you ever suffered from any of the following?	**Yes**	**No**
Heart murmur, heart valve defect or replacements?		
Chronic bronchitis, asthma or other respiratory disease		
Diabetes		
Epilepsy, blackouts, giddiness or fainting		
Hepatitis, jaundice, liver or kidney damage		
Excessive bleeding and/ or bleeding disorders		
High blood pressure or angina		
Heart disease, heart attack or any related complaints		
Has heart / pace-maker surgery ever been performed		
Undergone joint replacement operation		
HIV positive		
Had blood donation refused		
Any other serious illness or related medical condition		
Currently undergoing any medical treatment		
Are there any known allergies *(Please specify ……)*		
Are you pregnant? *(Baby due: ……/……/….…..)*		
Do you drink alcohol? *(Approx. how many units per week? ……)*		
Do you smoke? *(Approx. how many per day? ……..)*		
Any additional information you'd like the dentist to be aware of:		

Signed (Self/parent/guardian) …… Date ……..