Patient Name ..... **Medical History Update** **DOB .....**

Please confirm the following by ticking Yes or No

Life Style	Yes	No	Life Style	Yes	No
Do you Smoke/Vape			High sugar/frequency		
No. per day:			Lots of fizzy/acidic drinks		
Do you chew tobacco			Recreational drugs		
No. per day:			Pregnant or possibly pregnant		
Do you drink Alcohol			Anything the dentist should know		
Units per week:			Are you an ex-smoker		
Further Details					

Heart	Yes	No	Heart	Yes	No
Rheumatic Fever			Heart Murmur		
High/low blood pressure			Angina		
Heart Surgery			Thrombosis		
Pacemaker fitted			Other heart conditions		
Further Details					

Blood	Yes	No	Blood	Yes	No
Hepatitis A, B, C or D			Anaemia		
H.I.V./AIDS			Sickle Cell		
Abnormal Blood Test			Haemophilia		
Blood refused by transfusion svce.			Other blood conditions		
Further Details					

Allergies	Yes	No	Allergies	Yes	No
Penicillin			Latex Allergy		
Hay Fever			Medicines		
Anti Tetanus Serum			Plants		
Eczema			Foods		
General Anaesthetic			Aspirin		
Local Anaesthetic			Other allergy conditions		
Further Details					

Warnings	Yes	No	Warnings	Yes	No
Hearing/Sight Impairment (excluding Glasses)			Is your weight over 20 stone/127 kilos		
Antibiotic cover required			Taken steroids within 2 years		
Bruising or persistent bleeding			Do you carry a Warning Card/Medical Bracelet		
Currently under medical treatment			Recently admitted to hospital		
Further Details					

Chest	Yes	No	Chest	Yes	No
Bronchitis			Emphysema		
Cystic Fibrosis			Pneumonia		
Pleurisy			Chest Surgery		
Asthmatic			Other chest conditions		
Further Details					

Other	Yes	No	Other	Yes	No
Liver Disease			Kidney Disease		
Diabetes			Epilepsy		
Acid Reflux or Eating Disorder			Hiatus Hernia		
Bone or Joint Disease			Artificial Joint		
Fainting Attacks or Blackouts			Giddiness		
Past serious or infectious disease			Cancer/Radiotherapy		
Depressive Illness			Stroke		
Nervous Problems			Tuberculosis		
Severe Headaches			Cold Sores		

MEDICATIONS

Please can you list any current medications, tablets, pills or lotions you are taking

Patient Signature ----------

Date ----------