GODSTONE
DENTAL CARE

Medical History

Godstone Dental Care
24 High Street Godstone,
Surrey, RH9 8AG

Tel: 01883 744297
info@godstonedentalcare.co.uk
www.godstonedentalcare.co.uk

Personal Details

Mr Mrs Miss Ms

Surname:

Forename:

Address:

Postcode:

Tel no (home):

Tel no (business):

Date of birth: D D M M Y Y Y Y

Occupation:

Medical Information

Certain medical conditions can affect dental treatment and vice versa.
Please complete the following form by ticking the appropriate boxes and answering the questions. All details are strictly confidential.

Do you have or have ever suffered from:

Rheumatic Fever?	Y	Y	Excessive bleeding?
Hepatitis?	Y	Y	High Blood Pressure?
Diabetes?	Y	Y	Any other serious illness?
Epilepsy or fainting attacks?	Y	Y	Do you carry a warning card?
Chronic Bronchitis or Asthma?	Y	Y	Any heart complaint, heart surgery/stroke?

Are you:

Allergic to any medicine, tablets, substances or latex? Y N

(If yes, please list here):

At present taking any medicine or tablets? Y N

(If yes, please list here):

Pregnant? Y N

In the past two years:

Have you undergone any operations? Y N

Been treated with hydro-cortisone or corticosteroids? Y N

General Questions

Have you ever had a joint replacement operation? Y N

Please tick or tell the dentist if you are HIV positive Y N

What is your average weekly consumption of alcohol? UNITS

Do you smoke currently? Y N

If yes, what is your average per week:

If no, did you smoke in the past? Y N

(For how many years?)

(Weekly average?)

If you have ticked 'yes' to any questions please supply details in the 'notes' section below

Your Doctor's Details

Name:

Address:

Postcode:

Notes:

Review Details

Please check that all the information on this form is still correct.
Record the review plus any changes below.

Date of review: D D M M Y Y Y Y

Any changes?: Y N

Changes advised:

Patients signature:

Dentists signature: