Medical History Form

leo dental

Full Name: .....

Title: ..... DOB: ..... Sex: Male / Female .....

Home address: .....

.....

Mobile Telephone: ..... Home telephone: .....

Email address: .....

Occupation: .....

GP's name: ..... GP's address: .....

.....

Are you:	YES	NO	DETAILS
Attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Taking any medicines? (please complete medicine list at the end)			
Taking or have taken steroids in the last 2 years?			
Allergic to any medicine, foods, materials?			
Carrying a medical warning card?			
Wearing a pacemaker?			

Do you suffer from:	YES	NO	DETAILS
Asthma			
Bronchitis, Emphysema, COPD, other chest/ lung conditions			
Fainting, giddiness, blackouts, epilepsy			
Heart conditions, angina, stroke, heart surgery			
Diabetes			
Blood Pressure problems			
Arthritis or osteoporosis or other bone/ joint disorders			
Thyroid problems			
Liver or kidney disease, Jaundice			
Any infectious diseases e.g. HIV, Hepatitis B, C or D or HPV			
Hay fever, Eczema			

Have you ever had:	YES	NO	DETAILS
Radiotherapy or Chemotherapy			
A bad reaction to Local or General Anaesthetic			
Cold Sores			

Alcohol Consumption		DETAILS
How many untis of alcohol do you drink per week?		

Smoking/ Tobacco	YES	NO	DETAILS
Do you smoke any tobacco products now or in the past?			
Do you chew tobacco, paan, arecanut, supari, gutkha or did you in the past?			

Is there a possibility you may be pregnant?			
Have you had a baby in the last 12 months?			

Medicine Name	Dose	Frequency	What is the medication for?

Please read and check your medical history form. If there have been any changes please amend and circle yes.

Date	Y/N	Patient signature	Dentist signature