THE Wellesley DENTAL PRACTICE

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To obtain the best and safest treatment, your dentist needs to know of any problems which may affect your treatment.

Name:_____ Date of birth:_____

Address:_____

_____ Post Code:_____

Tel. Nos: Home:_____ Work:_____ Mobile:_____

E-mail: _____

Occupation:_____ Last dental visit:

Referred by:_____ Expectant mother: Yes / No

Your doctor's name & address:_____

_____ Post Code:_____

	YES	NO	DETAILS
ARE YOU:			
1. Attending or receiving treatment from a doctor, hospital, clinic or specialist?			
2. Taking any medicines from your doctor?			
3. Taking or have you taken steroids in the last two years?			
4. Allergic to any medicines, foods or materials?			
5. HIV positive?			
HAVE YOU:			
1. Had rheumatic fever or chorea (St. Vitus Dance)?			
2. Had jaundice, liver, kidney disease or hepatitis?			
3. Ever been told you have a heart murmur or heart problem, angina, blood pressure, heart attack?			
4. Had any blood tests, inoculations etc.?			
5. Ever had your blood refused by the blood transfusion service?			
6. Had a bad reaction to general or local anaesthetic?			
7. Had a joint replacement?			
8. Been hospitalised?			
DO YOU:			
1. Have arthritis?			
2. Have a pacemaker, or had any form of heart surgery?			
3. Suffer from hay fever, eczema or any other allergy?			
4. Suffer from bronchitis, asthma, or other chest condition?			
5. Have fainting attacks, giddiness, blackouts or epilepsy?			
6. Have diabetes or does anyone in your family?			
7. Bruise easily or have bleeding problems following tooth extraction, surgery or injury? Does any member of your family?			
8. Carry a warning card?			
9. Ever get cold sores?			

Are there any other aspects concerning your health that you think the dentist should know about?

Completed by: Self / Patient / Guardian - Signature

Date Updated