ARE YOU CURRENTLY	YES	NO	GIVE DETAILS
Pregnant. If yes, what is the expected delivery date?			
Have you had a baby in the past 12 months? If so what is their DOB.			
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?			
Carrying a medical warning card?			

HAVE YOU EVER SUFFERED FROM	YES	NO	GIVE DETAILS
Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?			
Bronchitis, asthma or other chest condition?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart problems, angina, blood pressure problems, or stroke?			
Diabetes (or does anyone in your family)?			
Bone or joint disease?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Liver disease (e.g. jaundice, hepatitis) or kidney disease?			
Any other serious illness or infectious disease?			
A bad reaction to general or local anaesthetic?			
A joint replacement or other implant?			
Treatment that required you to be in hospital?			
Heart surgery?			
Blood refused by the Blood Transfusion Service?			

ALCOHOL	UNITS PER WEEK
How many units of alcohol do you drink per week? *(A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitif.)*	

TOBACCO USE	YES	NO	IN PAST	QUANTITY per day
Do you smoke any tobacco products now (or did you in the past)?				
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)?				

PLEASE GIVE ANY OTHER DETAILS WHICH YOUR DENTIST MIGHT NEED TO KNOW ABOUT, SUCH AS SELF-PRESCRIBED MEDICINES (eg ASPIRIN) OR ANY DISABILITIES YOU MAY HAVE:

COMPLETED BY **Self / Parent / Guardian**

Patients Signature Date

Dentists Signature Date