ManorDentalCare
THE PAGET PARTNERSHIP

Title:	**Name:** **Date of Birth:**
Sex: Male Female	**Address:**
Tel (home):	**Post Code:**
Tel (work):	**Email address:**
Mobile:	**Date of last dental visit:**
Occupation:	**Your doctor's name and address:**
Do you have any Dental Insurance?	

Are you:	Please circle	Details:
1. Attending or receiving medical treatment from A doctor, hospital clinic or specialist?	Yes No	
2. Taking any prescribed medicines (eg. Tablets, Ointments, injections, inhalers-including Contraceptives or hormone replacement therapy)? Please give Details.	Yes No	
3. Taking or have taken Steroids in the last two Years?	Yes No	
4. Allergic to any medicines, foods, or materials? Please give Details.	Yes No	
5. Pregnant, trying to conceive or have had a baby in The last 12 months?	Yes No	
6. Had a joint replacement, or any other Implant?	Yes No	

Do You:	Please circle	Details:
1. Ever get cold sores?	Yes No	
2. Have Arthritis?	Yes No	
3. Have a pacemaker, or have you had any form of heart surgery?	Yes No	
4. Suffer from hay fever, eczema or any other allergy?	Yes No	
5. Suffer from bronchitis, asthma or other chest condition?	Yes No	

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6. Have fainting attacks, giddiness, blackouts or epilepsy?	Yes No	
7. Have diabetes or does anyone in the family?	Yes No	
8. Bruise easily? Or following a tooth extraction surgery or injury, do you or your family bleed so as to cause concern?	Yes No	
9. Carry a warning card?	Yes No	
10. Have any infectious diseases (including HIV or Hepatitis)?	Yes No	
11. Do you suffer from heart problems, Angina, Blood Pressure problems or stroke?	Yes No	
12. Do you smoke? If yes how many a day? Or have you smoked in the past?	Yes No	
13. Any other information you feel your dentist should know about?	Yes No	

14. If any, how many units of Alcohol do you Consume per week?		
15. Have you ever had rheumatic fever ?	Yes No	
16. Have you ever had liver, Kidney Disease	Yes No	
17. Have you ever had blood refused from the Blood Transfusion Service?	Yes No	
18. Have you ever had a bad reaction to general or local anaesthetic?	Yes No	
19. Do you believe you are in good health?	Yes No	
20. Are you happy with the appearance of your teeth? If not why?	Yes No	

By signing this Medical History Form you consent to the disclosure of your dental notes and other Records for the purpose of any review, assessment or consideration of the care provided by your dentist, which may take place in the fulfilment of the Manor Dental Clinical Governance Policy; but not for any other purpose without your further consent.

Completed by Self / Parent / Guardian:
Signature: Date:

MH Checked Date : Signature :	MH Checked Date : Signature :	MH Checked Date : Signature :