CONFIDENTIAL MEDICAL HISTORY FORMS

NAME:			
D.O.B.			
ADDRESS: POST CODE:			
Home Telephone: Mobile: Work:			
E-mail address:			
GP DETAILS: NAME: Address: TEL:	In case of emergency please contact: NAME: CONJTACT NUMBER: RELATIONSHIP		
Have you:	YES	NO	MEDICATIONS – continue overleaf if necessary
Are you pregnant/ possibly pregnant?			
Any Type of heart complaint? (Heart attack/murmur/ pacemaker/stroke etc)			
Any problems with Blood Pressure?			
Any chest/breathing complaint? (asthma/ bronchitis/ Apnoea)?			
Any bleeding disorder/ on Blood thinning medication? (Haemophilia, Warfarin, Aspirin, etc)			
Any allergies or unusual side effects from medication, injections, anaesthetics?			
Any type of diabetes?			
Any types of epilepsy/ history of convulsions/ fainting?			
Any type of liver/ kidney disease? Including hepatitis/ Jaundice?			
Any stomach/bowel problem?			
Osteoporosis/ Arthritis?			
Ever had cancer/ tumours?			
Ever had chemotherapy / radiotherapy?			
Do You:			
Drink Alcohol? If so, how many units/pints?			
Smoke? If so, how many per day?			
Any other medication?			

Signature_____ Date_____

"I consent */ DO NOT Consent* to Orchard Family Dental sending me text messages and emails regarding appointments etc." please delete as applicable*

Signature_____ Date_____