Medical History Form

NW LONDON Smile CENTRE
Dentistry & Facial Aesthetics

Title: ..... Forename: ..... Surname: .....

DoB: ..... / ..... / ..... Gender: ..... Occupation: .....

Address: .....

Telephone: ..... Email: .....

GP Details: .....

Are you currently...	Yes / No	Details
Receiving treatment from a doctor, hospital or clinic?		
Taking any prescribed medicines (tablets, ointments, inhalers)?		
Carrying a warning card?		
Taking or taken steroids in the last two years?		

Do you suffer from...	Yes / No	Details
Allergies to any medicines, foods or materials?		
Hay fever or eczema?		
Fainting attacks, giddiness, blackouts or epilepsy?		
Have diabetes or does anyone in your family?		
Arthritis?		
Bruising or persistent bleeding following injury, tooth extraction or surgery?		
Any infectious diseases (including HIV or hepatitis)?		

Did you, as a child or since, have...	Yes / No	Details
Rheumatic fever or chorea?		
Liver disease (jaundice, hepatitis) or kidney disease?		
Blood refused by the Blood Transfusion Service?		
A bad reaction to general or local anaesthetic?		
A joint replacement or other implant?		
Treatment that required you to be in hospital?		
Heart murmur or heart problem, angina, blood pressure problems or heart attack?		
Brain Surgery?		

Alcohol...	Yes / No	Details
How many units 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	Details
Do you smoke any tobacco products now or did you in the past? (we strongly advise against this)		
Do you chew tobacco, pan, use gutkha or supari now or did you in the past?		

Completed by: PATIENT / GUARDIAN Date: ..... / ..... / ..... Signature: .....

Medical History Update...

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

Date	Any Change?	List Any Changes Below	Patient's Initials