

WELLINGTON DENTAL PRACTICE

CONFIDENTIAL MEDICAL HISTORY

PATIENT DETAILS

Gender		Email Address		Doctor's Name	
Title			Home Telephone		Medical Surgery Address
First Name		Mobile Telephone			
Surname			Work Telephone		Emergency Contact
D.O.B.		Occupation			Name
Address			Ethnicity		Relationship
					Telephone number
Postcode					

MEDICAL HISTORY (PLEASE PROVIDE / ATTACH DETAILS OF ANY MEDICAL CONDITIONS AND MEDICATION)

Heart	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Pacemaker Fitted	<input type="checkbox"/> Heart mummer	<input type="checkbox"/> Angina	<input type="checkbox"/> Thrombosis	
Other Heart Conditions / Further Details								
Chest	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Chest Surgery	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Pleurisy		
Other Chest Conditions / Further Details								
Blood	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> H.I.V.	<input type="checkbox"/> Anaemia	<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Haemophilia		
Other Blood Conditions / Further Details								
Other	<input type="checkbox"/> Serious Childhood Illness	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Cancer	<input type="checkbox"/> General Anaesthetic Experience	<input type="checkbox"/> Hiatus Hernia
Allergies	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Hay- Fever	<input type="checkbox"/> Anti-Tetnus Serum	<input type="checkbox"/> Eczema	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Asthmatic	<input type="checkbox"/> Latex	
Other Conditions or Allergies								

MEDICATION LIST

Do you smoke?	<input type="checkbox"/> Y <input type="checkbox"/> N	How many per day? How long have you been smoking?		Signature	
Do you drink alcohol?	<input type="checkbox"/> Y <input type="checkbox"/> N	How many units per week?		Today's Date	
Are you Pregnant?	<input type="checkbox"/> Y <input type="checkbox"/> N	What is your due date?			

