Stevenage Dental Studio & Implant Centre

93-95 Queensway
Stevenage
Herts. SG1 1EA
Tel: 01438 318414

Mr Mrs Ms Miss Dr Other

Name……………………………………………….

Home Address……………………………………..
……………………………………………………….
……………………………………………………….

Post code……………………………………………

Home Phone……………………………………..

Mobile Phone……………………………………
E-mail………………………………………………

Name of Doctor…………………………………
Address…………………………………………….
……………………………………………………….
……………………………………………………….

Post code……………………………………………

Phone……………………………………………….

Date of Birth………………………………………..
Occupation………………………………………….
Work Address……………………………………...
……………………………………………………….
……………………………………………………….

Post code……………………………………………

Work Phone………………………………………...

Name, Address and Phone no: of any medical consultants or specialists that you see

Name……………………………………
Telephone no:……………………………
Address…………………………………..

Recommended by…………………………………..

Confidential Medical History

Please look at the following list, and circle Yes/No as applicable. Please complete both sides of each page. This information will be kept strictly confidential.

1. Are you attending or receiving treatment from a doctor, hospital, clinic or specialist? Yes No
If yes, Please give details……………………………………………………………………………………………
…….

2. Have you consulted a medical doctor in the last year-if so give details. Yes No
………
…….

3. Are you currently on any medication? Please give name and dosage Yes No
……..
…….
……..

4. Are you taking or have taken steroids? If yes please give details…………………………….. ……..Yes No
…….

Have you got or have you had?

5. Heart disease, Angina (Chest pain), Rheumatic fever, Heart murmurs, Heart Attack, Congenital heart disease, Palpitations or blackouts? If yes, Please circle as appropriate and give details ………………………………………………………………………………………………. Yes No
…….

6. High blood pressure (Hypertension)? Date of last test……………………….Reading……./…….. Yes No

7 Stroke? If yes in which year………………………………………………………………………………..

8. Blood disorder (Anaemia,Sickel cell disease,thalassemia)If yes Please give details ……………………………….
………

9. Blood clot (Thrombosis or embolism in the legs or lungs) If yes please give details Yes No
…….

10. Do you suffer from Diabetes.If the answer is yes, is it contolled by Diet Tablets Insulin Yes No

11. Lung Disease(Asthma,,Bronchitis,TB, Shortness of breath climbing a flight of stailrs or lying flat) Yes No
If yes, Please circle as appropriate and give details …………………………………………………………………..
……
……..

12. Do you bruise easily or bleed excessively from cuts or tooth extractions? Yes No

13. Have you or any relation had any severe prolonged bleeding problems?) If yes please give details Yes No
……….
……….

14. Have you ever had any ill effect following dental treatment ………………………………………… Yes No
………

15. Are you allergic to any of the following: (Latex , Penicillin or amoxicillin ,Any other antibiotic , Aspirin, Local anaesthetic, Sedative Iodine,elastoplast or any other foods)
Yes No

16. Any other allergies……………………………………………………………………………… Yes No

17. Do you regularly take aspirin or any similar medication Yes No

18. On exertion , do you have chest pains or shortness of breath or palpitation Yes No

Have you got or ever had?

19. Porphyria or other medical disorder? If yes please give details……………………………………….. Yes No
……

20. Neurological disease? If yes please give details…………………………………….. Yes No
……

21. Liver disease(Hepatitis , Jaundice) If yes please give details…………………………………….. Yes No
……

22. Kidney disease or ‘ waterworks’ problems If yes please give details…………………………… Yes No
……

23. Muscle problem(Myopathy,dystrophyor progressive weakness)? If yes please give details Yes No
……

24. Arthritis? If yes please give details…………………………………….. Yes No
……

25. Sinus problem If yes please give details…………………………………….. Yes No
……

26. Hereditary disease in the family If yes please give details…………………………………… Yes No
……

27. Any other medical condition? If yes please give details…………………………………….. Yes No
……

28 Have you been admitted into hospital ? If yes please give details…………………… Yes No
……

29. Have you ever had an operation? If yes please give details…………………………………… Yes No
……

30. Have you ever had prolonged illness? If yes please give details……………………… Yes No
……

31. Have you ever had a general anaesthetic? If yes please give details……………………… Yes No
……

32. Have you had intravenous sedation(any problem)Please give details with the last date Yes No

33. Have you or any member of the family had any problem with anaesthetic? If yes please give details Yes No
……

34. Do you carry a medical warning card or bracelet Yes No

35. Do you have osteoporosis Yes No

36. Have you had a joint replacement Yes No

37. Have you ever had any fits Yes No

38. Do you take any of the following medication (Antibiotics, Anticoagulants, Blood pressure tablets, Diuretics(water tablets), Steroids, tranquillisers, antidepressants, antihistamines, aspirin, insulin, harmones, Bis phosphonates- Fosamide,Alendronic acid, Any other
Please encircle as appropriate and give details…………………………………………………………………………….
……..
……………………………………………………………………………………………………Yes No

39. Do you have any of the following,
Contact lenses………………………………………………………………………………. Yes No
Hearing aids……………………………………………………………………………... Yes No
Pacemaker or other non dental implants……………………………………………………… Yes No

40. For female patients
Are you taking the contraceptive pill?.. Yes No
Could you possibly be pregnant?... Yes No

41. Do you smoke? If Yes, how many per day?... Yes No

42. Do you drink alcohol? If Yes, how many units per day?.............../units per week…………………. Yes No

43. Do you take any recreational drugs?.. Yes No

44. Is there any aspect concerning your health that we should know about?... Yes No
Please give details…………………………………………………………………………………………..

45. Do you suffer from any infectious diseases?.. Yes No

46. Are you HIV or Hepatitis B or C positive?... Yes No

If there is anything you would like to discuss but prefer not to write down, please tick here and your dentist will discuss this with you……………………………………………………………………………………………………☐

46. Is there any relevant information that you think would be helpful?...Yes No
…….
……

Patient Signature…………………………………………………………Date……………………………………………….

Medical History Updated

Patient Signature…………………………………………………………Date……………………………………………….

Patient Signature…………………………………………………………Date……………………………………………….

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