RIVERSIDE DENTAL PRACTICE
PATIENTS MEDICAL HISTORY & INFORMATION SHEET

PERSONAL DETAILS

Full Name:	Date of Birth:
Address: Postcode:	Email Address:
Telephone Number (s) Home: Mobile: Work:	

WHERE DID YOU HERE ABOUT RIVERSIDE DENTAL? (Please circle)

Personal Recommendation	Social Media	Event	Other (please state)

MEDICAL CONTACT DETAILS

Doctors Name & Address:	Doctors Phone Number:

EMERGENCY CONTACT DETAILS

Name:	Relationship:	Telephone Number:

MEDICAL QUESTIONNAIRE

Questions	Yes	No	Details
Are you currently pregnant?			
Are you currently receiving treatment from a doctor, hospital or clinic?			
Are you currently taking any prescribed medication Are you taking any medication containing Bisphosphonates?			
Are you carrying a medical warning card?			
Do you suffer from any allergies to medicines (e.g. penicillin, chlorhexadine), substances (e.g. latex or rubber) or foods?			
Do you suffer from Hay fever or eczema?			
Do you suffer from bronchitis, asthma or other chest conditions?			
Do you suffer from fainting attacks, giddiness, blackouts or epilepsy? If yes when was your last seizure?			
Do you suffer from heart problems, angina, blood pressure problems or stroke?			
Are you diabetic (or is anyone in your family)?			
Do you suffer from bruising or persistent bleeding			

following injury, tooth extraction or surgery?			
Have you ever had rheumatic fever or chorea?			
Do you suffer from any infectious diseases (including HIV and hepatitis)?			
Have you ever had liver disease (e.g. jaundice, hepatitis) or kidney disease?			
Have you ever had blood refused by the Blood Transfusion Service?			
Have you ever had a bad reaction to general or local anaesthetic?			
Have you ever had a joint replacement or any other implant?			
Have you ever had treatment that required you to stay in hospital?			
If you drink alcohol, how many units of alcohol do you drink per week?			
Do you smoke? If yes how many do you smoke & how long have you smoked for.			
Do you suffer from snoring or sleep apnoea?			
Are you aware of clenching/grinding your teeth			
Do you wake up suffering from pain in your head or neck?			

MEDICAL DETAILS

Please provide details of any medication you are currently taking including, dosage and frequency below:

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Patient Name_____ **Patient Signature**_____
Date_____

We understand any information supplied will be STRICTLY CONFIDENTIAL