Confidential Medical History Form

Name :

Date of Birth:

Home Address:

Email Address:

Contact Tel No:

GP name and address:

PPS number:

Medical Card number:

Medical Status

1. Are you fit and well at present?

2.Do you have a cough, fever ,sore throat ,or loss of taste or smell ?

3.Are you attending a doctor for any specific complaint?

4.Are you taking any medication at present?
e.g.aspirin,anticoagulants ,osteoporosis medication

5 Have you high blood pressure?

6.Have you a heart complaint ? e.g. angina ,surgery,murmur

7.Are you asthmatic ?

8.Are you epileptic?

9.Have you any allergies eg Penicillin ?

10.Do you have a bleeding disorder?

11.Have you been hospitalised or received prolonged medical treatment in the past,including the taking of
steroids?

12.How long has it been since your last dental visit?

13.Are there any other details which your dentist may need to know?

Signature: