15
FIFTEEN
DENTAL

Confidential Medical History

A: Are you

1. Attending or receiving any treatment from your doctor, hospital, clinic or specialist?
   Yes No

2. Taking any medicines or tablets prescribed by your doctor?
   Yes No

3. Allergic to penicillin or any other drug or substance or foods (e.g. Latex/rubber)?
   Yes No

4. Pregnant or likely to be so?
   Yes No

B: In the past have you

1. Ever had a heart problem, angina, high or low blood pressure, heart attack or stroke?
   Yes No

2. Ever had rheumatic fever?
   Yes No

3. Ever had jaundice, hepatitis, liver problems or kidney disease?
   Yes No

4. Ever had asthma, bronchitis, hay fever or any serious chest infections?
   Yes No

5. Ever had any blood related diseases?
   Yes No

6. Ever had a bad reaction to a local general anaesthetic?
   Yes No

7. Ever had an operation or received hospital treatment?
   Yes No

8. Ever had a heart valve replaced?
   Yes No

9. Had a blood transfusion from the Blood Transfusion Service?
   Yes No

10. Had growth hormone treatment before the mid 1980s?
    Yes No

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C: Do you

1. Have a pacemaker?
   ◯ Yes ◯ No

2. Have fainting attacks, giddiness or epilepsy?
   ◯ Yes ◯ No

3. Have diabetes?
   ◯ Yes ◯ No

4. Carry a warning card?
   ◯ Yes ◯ No

5. Bruise easily or have you ever bled excessively?
   ◯ Yes ◯ No

6. Take or have you ever taken steroids?
   ◯ Yes ◯ No

7. Do you smoke? Typically how many per day?
   ◯ Yes ◯ No

8. Have a close relative (parent, sibling, grandparent or grandchild) with Creutzfeldt Jakob Disease?
   ◯ Yes ◯ No

9. Drink alcohol (A unit is half a lager, a single Measure spirit or glass of wine? How many units per week?
   ◯ Yes ◯ No

10. Suffer from headaches or migraine?
    ◯ Yes ◯ No

11. Suffer from Arthritis?
    ◯ Yes ◯ No

12. Have any infectious diseases such as HIV, CJD or Hepatitis, if so, what?
    ◯ Yes ◯ No