Patient Medical History Update Sheet

In order for this dental practice to provide the highest standard of care, it is requested that you fill in this form carefully and thoroughly

Full Name : …… D.O.B …… Email: ……

Address (If Different to previous): ……

Dental Insurance : ……

Please tick all that applies to you. If nothing applies please cross(//) the page and sign at the bottom

Conditions	✓	Any Details
High Blood Pressure		
Heart problems		
Rheumatic fever		
Artificial Joint / Heart valve		
Blood disorders / Thinners		
Allergies to medications/ latex		
Asthma		
Sinus trouble		
Epilepsy		
Diabetes		
Tumour History		
Radiation Treatment		
Hepatitis (A/ B/ C/ D /E)/ HIV		
Ulcers (stomach)		
Liver disease		
Kidney disease		

Medication

…… ……

…… ……

…… ……

Lifestyle

Smoke per day Y/N

Pregnant/possible Y/N If Yes Due date : ……

Warnings

Hearing/sight impairment Y/N

Antibiotic cover required Y/N

Do Not Recline Y/N

Anything dentist should know……..

I have completed this questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place ME at undue medical risk.

On future visits, any changes to the above should be advised

Signed…… Date……