Medical History - Independent Living

The Village Dentist

All information will be treated with complete professional confidentiality

Patient Name _____ Date of birth _____

Who is your general practitioner? _____ Contact Details _____

Have you had any health problems in the past year? _____

Current medications _____

Have you ever had any adverse reaction to any treatment or medication? **YES** **NO** Specify _____

Are you allergic to any drugs or medications? **YES** **NO** Specify _____

Are you allergic to latex? **YES** **NO** _____

Are you a smoker / have you ever smoked? **YES** **NO** _____

HAS THE PATIENT HAD OR HAVE THEY EVER HAD THE FOLLOWING? (PLEASE CIRCLE YES OR NO)		
High blood pressure	**YES**	**NO**
Heart condition (Rheumatic fever, valve replacement, heart surgery)	**YES**	**NO**
Central nervous system e.g. strokes, shunts	**YES**	**NO**
Have you been advised to take antibiotics prior to dental treatment	**YES**	**NO**
Hip, knee or other joint replacement in the last 12 months	**YES**	**NO**
Lung disease, Asthma, chest problems	**YES**	**NO**
Blood or bleeding problems	**YES**	**NO**
Diabetes / Thyroid	**YES**	**NO**
Liver / kidney disease (e.g. hepatitis)	**YES**	**NO**
Gastrointestinal	**YES**	**NO**
Epilepsy / fits / seizures	**YES**	**NO**
Cancer (chemotherapy / radiotherapy)	**YES**	**NO**
Immune system disorders (e.g. HIV, chronic fatigue)	**YES**	**NO**
Complications with local analgesia or general anaesthetic	**YES**	**NO**
Any serious operation, illness or stay in hospital longer than 1 month	**YES**	**NO**
Infectious diseases e.g. hepatitis, MRSA, Tuberculosis, CSJ, other	**YES**	**NO**
Mobility / balance problems (if yes please complete mobility form)	**YES**	**NO**
Special diet	**YES**	**NO**

If yes for any of the above please provide details _____

Signature _____ Date _____

Dental Notes

(For office use only)

The Village Dentist

Date	Details