**CONFIDENTIAL CONTACT AND MEDICAL HISTORY FORM FOR:**

 **Name Date of birth Occupation**

 **ADDRESS:**

 **POSTCODE:**

 **Tel: home mobile work**

 **Email Address for correspondence:**

 **Dr’s Name and Medical centre:**

 **Do you smoke Yes / No If yes how many per day............?**

 **How many units of alcohol do you have per week ..........?**

 **(I unit =half a pint or a small glass of wine/spirit)**

**-----------------------------------------------------------------------------------------------------------------------------------------------------------**

 **Are you: (tick yes or no) YES NO**

 **Receiving treatment from a doctor, hospital or clinic?**

 **Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers?**

 **Carrying a medical warning card?**

 **Pregnant or possibly pregnant?**

 **Allergic to medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods?**

 **Bronchitis, asthma or another chest condition?**

 **Fainting attacks, giddiness, blackouts, epilepsy?**

 **Heart problems, angina, blood pressure problems or stroke**

 **Diabetes**

 **Bone or joint disease?**

 **Bruising or persistent bleeding following injury, tooth extraction or surgery?**

 **Liver disease (e.g. jaundice, hepatitis) or kidney disease?**

 **Any other serious illness or other information your dentist should know**

***If you answered yes to any questions, please give details in the box below eg: full list of medical conditions/ medications taken***

Medical history notes:

 Completed by self parent

Signed -------------------------------------------------------- Date.........................................