**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.........................................