zandielle

Dental | Facial Aesthetic | Eyecare Clinic

Confidential Medical History Form

TITLE SURNAME FORENAME

ADDRESS

SEX DOB

OCCUPATION

ETHNICITY

POSTCODE

TELEPHONE NUMBER

MOBILE

WORK

HOME

EXPECTANT MOTHER

YES NO

DO YOU CARRY A WARNING CARD? YES / NO

WHAT IS YOUR PREFERED METHOD OF CONTACT?

EMERGENCY CONTACT NUMBER:

RELATION:

DOCTORS NAME AND ADDRESS

DO YOU HAVE ANY ALLERGIES?

YES: NO:

ALLERGIES:

ARE YOU RECEIVING ANY TREATEMENT FROM A HOSPITAL/DOCTOR/SPECIALIST CLINIC: YES NO

PLEASE GIVE A LIST OF MEDICATIONS YOU ARE TAKING (OR PROVIDE A REPEAT PRESCRIPTION TO COPY)

DO YOU: (**PLEASE CIRCLE THE ANSWERS**)

SUFFER FROM BLOOD PRESSURE PROBLEMS?	YES	NO
SUFFER FROM HAYFEVER, ECZEMA, OR ASTHMA?	YES	NO
SUFFER WITH FAINTING ATTACKS, DIZZINESS, OR EPILEPSY?	YES	NO
SUFFER FROM ARTHRITIS?	YES	NO
BRUISE EASILY OR HAVE PERSISTANT BLEEDING AFTER SURGERY OR TOOTH EXTRACTION?	YES	NO
HAVE ANY INFECTIOUS DISEASES (INCLUDING *HIV, HEPATITIS)?*	YES	NO
HAVE YOU HAD:		
RHEUMATIC FEVER, CHOREA, LIVER DISEASE (JANUNDICE) OR KIDNEY DISEASE?	YES	NO
YOUR BLOOD REFUSED BY A BLOOD TRANSFUSION SERVICE?	YES	NO
A BAD REACTION TO GENERAL OR LOCAL ANAESTHETIC?	YES	NO
A JOINT REPLACEMENT OR OTHER TYPE OF IMPLANT?	YES	NO
HEART SURGERY? OR BEEN DIAGNOSED WITH ASSOCIATED HEART PROBLEMS?	YES	NO
HAS A CLOSE RELATIVE (PARENT, SIBLING, CHILD, GRANDPARENT OR GRANDCHILD BEEN DIAGNOSED WITH CREUZFELDT JAKOB DISEASE (CJD)	YES	NO

HOW MANY UNITS OF ALCOHOL DO YOU CONSUME PER WEEK?

A UNIT IS ½ PINT OF LAGER, A SINGLE MEASUREMENT OF SPIRIT OR A GLASS OF WINE — UNITS ☐

DO YOU SMOKE OR CHEW ANY TOBACCO PRODUCT?

IF SO, PLEASE GIVE DETAILS OF HOW MANY A DAY. — QTY: ☐

COVID:

HAVE YOU HAD COVID-19?	YES	NO
HAVE YOU BEEN TESTED FOR COVID?	YES	NO
WAS YOUR RESULT	POSITIVE OR NEGATIVE	

HOW DID YOU HEAR ABOUT ZANDIELLE CLINIC? ☐

WOULD YOU LIKE PROMOTIONS /OFFERS SENT TO YOU? — YES — NO

(IF YES) HOW WOULD YOU LIKE TO BE CONTACTED? EMAIL ☐ TEXT ☐ SMS ☐