Cochrane Dental Care: Medical History

Name: _____

GP Details: _____

Social History:

Do you smoke? ☐ Number of cigarettes per day ☐

Do you drink alcohol? ☐ Number of units per week ☐

Do you have heart disease?

Rheumatic Fever	☐	Heart Murmur	☐
High Blood Pressure	☐	Angina	☐
Heart Surgery	☐	Heart Attack	☐
Pacemaker fitted	☐	Thrombosis	☐

Do you have chest problems?

Bronchitis	☐	Emphysema	☐
Cystic Fibrosis	☐	Pneumonia	☐
Pleurisy	☐	Chest Surgery	☐
Asthma	☐	Other Conditions	☐

Do you have any blood disorders?

Hepatitis B	☐	Anaemia	☐
HIV	☐	Sickle Cell	☐
Bruising/Persistent bleeding	☐	Heamophilia	☐
Blood refused by transfusion service	☐	Other Blood Conditions	☐

Medications

Allergies

Penicillin	☐	Latex Allergy	☐
Hay Fever	☐	Medicines	☐
Anti Tetanus Serum	☐	Plants	☐
Eczema	☐	Foods	☐
General Anaesthetic	☐	Aspirin	☐
Local Anaesthetic	☐	Other Allergies	☐

Other conditions

Liver Disease	☐	Kidney Disease	☐
Diabetes	☐	Epilepsy	☐
Acid Refelux or Eating Disorder	☐	Hiatus Hernia	☐
Bone or Joint Disease	☐	Artifical Joint	☐
Fainting or Blackouts	☐	Giddiness	☐
Serious Illness	☐	Cancer	☐

Patient Signature _____ Date _____

Dentist Signature _____