Dear Patient,

thank you for updating us about your details and your medical history. It is important for us to know your medication and medical conditions as it could affect your dental treatment. Good practice requires a written update for every dental examination.

Thank you for your time.

Title: ________________
First name: __________ Surname: _______________

Date of Birth: _______________ Sex: female ☐ male ☐ Occupation: ________________________

Address: ____________________________________ Telephone: ________________________

____________________________________ Mobile: ________________________

Postcode: ____________________ Email: ____

Doctor (GP): ___________________________________ Work number: ________________________

Surgery: ____________________________________ Next of kin: ________________________

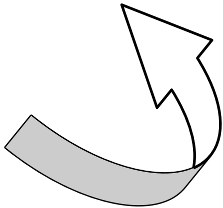
Last Dental Examination (year): ________________ Contact number: ________________________

1. **List of Medication:**
(please write down the name and dosage of the medication,
if you have a prescription list, please give it to the receptionist to be scanned.)

⇩ Medication	⇩ dosage

2. **Are you:**
(please circle either Y for yes or N for no)

	⇩ *details*
Likely to be pregnant ------------	*(due date)* ________________
Receiving any treatment from a Doctor------------------------	
Taking or have taken steroids in the last 2 years ---	
Allergic to Medication --------	
to Foods ----------------	
to Materials -----------	



*please **turn over***

3. Have you ever had:
(please circle either Y for yes or N for no)

Jaundice ----------------------------

Liver disease ----------------

High Blood Pressure ---------

Low blood Pressure ------

HIV -------------------------------------

Hepatitis -----------------------

Rheumatic fever ----------------

Stroke ---------------------------

Endocarditis ----------------------

vCJD -----------------------------

Heart attack ----------------------

Diabetes------------------------

Atrial Fibrillation ----------------

Epilepsy ------------------------

Heart surgery -------------------- ___________ (year)

Pacemaker ------------------------ ___________ (year)

Hip/Joint replacement -------- ___________ (year)

Valve replacement ------------ ___________ (year)

Bad reaction to Local or General Anaesthetic ---------

Do you smoke? -----------------

Weekly Alcohol intake in units
(1 pint of beer equals 2 units, 1 large glass of wine equals 3 units): __________ units.

Patient's signature	date	Dentist's signature	date

(Optional)

- I would like to get more information about teeth whitening ---------------------
- I would like to discuss treatment options to straighten my teeth --------------
- Hereby I give my consent to have clinical photographs taken and to have these published for advertisement and social media websites. No names will be published ----------------

Patient's signature	date