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: _

Surname: ___________

Date of Birth: ______________ Sex: female ☐ male ☐ Occupation: ______________________

Address: _________________________________ Telephone: ______________________

_________________________________ Mobile: ______________________

Postcode: __________________ Email: _______________________________________

Doctor (GP): ________________________________ Work number: ______________________

Surgery: _________________________________ Next of Kin/ Emergency contact: ______________

Last Dental Examination (year): _______________ Contact number: ______________________

Data protection:
We process personal data for the purposes of providing optimum dental healthcare. You can withdraw your consents at any time. Your preferred way of contact is

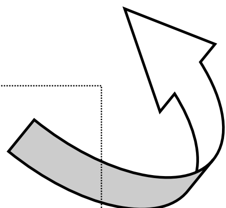
by Email ☐

by SMS text ☐

For further details about how we process your personal information and your data rights please see our Privacy Notice at www.witneydentalpractice.co.uk or contact us at *enquiries@witneydentalpractice.co.uk or* request a copy from reception.

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



*please **turn over***

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 ----------- ____________________

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

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

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

Low Blood Pressure-------------

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

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

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

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

Heart surgery --------------------- ____________ (year)

Pacemaker ------------------------ ____________ (year)

Valve replacement -------------- ____________ (year)

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

Cancer------------------------------ ____________ (year)

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

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

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

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

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

Asthma------------------------------

Any other illness------------------ ____________________

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

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

Do you play contact sport -

Alcohol units a week ____________

____________	____________	____________	____________
Patient's signature	**date**	**Dentist's signature**	**date**