temple dental
home care

MEDICAL HISTORY

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PLEASE ANSWER ALL QUESTIONS ON THE FORM OR IT MAY BE RETURNED

1. Are you currently receiving treatment from a Doctor, hospital or clinic? Yes / No .....

2. Please name all medications you are taking or ointments you are using: .....

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3. Are you currently taking any self-prescribed medicines eg aspirin Yes / No .....

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4. Do you have any allergies to any medicines or materials eg penicillin or latex? Yes / No .....

5. Do you carry a medical warning card? Yes / No .....

6. Do you suffer from hayfever or eczema? Yes / No .....

7. Do you suffer from arthritis or osteoporosis? Yes / No .....

8. Have you ever had heart surgery or had a pacemaker fitted? Yes / No .....

9. Do you suffer from heart problems, blood pressure or stroke? Yes / No .....

10. Are you or anyone in your family diabetic? Yes / No .....

11. Do you suffer from persistent bleeding following injury, tooth extraction or surgery? Yes / No .....

12. Have you ever had rheumatic fever, chorea or endocarditis? Yes / No .....

13. Do you suffer from bronchitis, asthma or other chest problems? Yes / No .....

14. Have you had, or do you have any form of cancer? Yes / No .....

15. Have you ever taken bisphosphonates? Yes / No .....

16. Do you suffer from cold sores? Yes / No .....

17. Have you ever had liver disease eg jaundice? Yes / No .....

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18. Do you suffer from fainting attacks, giddiness, blackouts or epilepsy? Yes / No .....

19. Have you ever had a bad reaction to local or general anaesthetic? Yes / No .....

20. Have you ever had a joint replacement or other implant? Yes / No .....

21. Have you ever had treatment that required you to stay in hospital? Yes / No .....

22. Did you receive growth hormone treatment before the 1980's? Yes / No .....

23. Have you had brain surgery? Yes / No .....

24. Do you drink more than 14 units of alcohol per week? Yes / No .....

25. How many fizzy drinks do you drink in a week? .....

26. Did you or do you smoke/chew any tobacco products or use guthka or supari? Yes / No .....

27. Are you currently pregnant or have you had a baby in the last 12 months? Yes / No .....

28. Do you suffer from any infectious diseases eg HIV or hepatitis? Yes / No .....

29. Have you ever had blood refused by the blood transfusion service? Yes / No .....

30. Do you have any other serious illnesses we have not described above? Yes / No .....

Please use this space to make any further notes about your medical history: .....

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Please give your Doctors Name: ..... Telephone: .....

Address: .....

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Patient signature: ..... Date: ...../...../.....