MAGNOLIA HOUSE
DENTAL PRACTICE

Title:_____ Surname: _____ First name: _____

DOB: _____ Gender: _____

Address:

_____

Post code: _____

Tel No: Home _____ Work _____Mobile _____

Email address: _____ Occupation: _____

Doctor's name and address: _____

	YES	NO
Are you attending or receiving treatment from any doctor/hospital? If yes, please give details:		
Have you ever had or being treated for cancer? If yes, please give details:		
Are you allergic to any medicines/foods/materials? If so, please give details:		
Are you likely to be pregnant?		

Have you ever suffered from:

Heart problems such as angina, heart attack, artificial valve/pacemaker?		
Blood problems such as: high/low blood pressure, stroke, anaemia, or prone to bleeding?		
Breathing problems such as asthma, COPD or bronchitis?		
Jaundice, liver or kidney disease?		
Blood borne diseases such as HIV, Hep A/B/C?		
Bone diseases such as arthritis or osteoporosis?		
Diabetes?		
Have fainting attacks, giddiness or epilepsy?		
Intestinal disorders such as stomach ulcers or Crohn's disease?		
Skin conditions such as eczema or cold sores?		
Adverse reaction to local/general anaesthetic?		
Had a major operation or recently received hospital treatment?		

PTO

Do you:

	Yes	No
Carry a warning card? If so, please give details:		
Smoke? If yes, how many a day:		
Drink alcohol? If yes, how many units/week		

If you are currently taking any medication, please list below alongside dosages that you are aware of:

Medication	Dosage

Signed: _____ Date: _____

Checked by: _____Date: _____
(Dentists)

PLEASE HAND YOUR MEDICAL FORM TO YOUR DENTIST