Confidential Medical History

Are you?	No	Yes	Details
Under treatment from your doctor, a hospital or clinic?			
Taking any medication (tablets, pills, medicines, inhalers, creams, ointments, injections)			
Allergic to anything(antibiotics, pollen or any other substance)			
Pregnant			
Have you ever had?			
Rheumatic fever or chorea			
Any heart problem (angina, heart attack, stroke, heart murmur, valve replacement, high or low blood pressure)			
Any chest problems (bronchitis, asthma, tuberculosis)			
Hepatitis (jaundice), liver or kidney disease			
Epilepsy, fainting or giddiness			
Any other serious illnesses or been hospitalised			
A joint replacement			
Blood refused by the transfusion service			
Do you?			
Have diabetes			
Have a pacemaker			
Have arthritis			
Bruise easily or bleed excessively			
Carry a warning card			
Do you smoke? If yes detail how many			

Patient Signature:	Date:
Dentist Signature	Date: