hamilton road
dental practice

MEDICAL HISTORY FORM

MEDICAL HISTORY UPDATED:

Patients Signature Date

Name: _____

Date of Birth: _____

Address: _____

_____

_____

Post Code: _____

Telephones
Home: _____

Mobile: _____

Work: _____

Email: _____

Preferred Method of Appointment Notification (please tick your choice)

Letter ☐ Phone ☐

Text ☐ Email ☐

Doctors Name & Address:

_____

_____

_____

_____

Please list any medication currently being taken here:

_____

_____

_____

_____

_____

Medical Alerts (e.g. Penicillin Allergy, Warfarin, Antibiotic Cover):

_____

_____

_____

CONFIDENTIAL PATIENT MEDICAL HISTORY

t. 01698 263099
e. reception@hrdp.co.uk
w. www.hrdp.co.uk

168 hamilton road
motherwell
ML1 3DW

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MEDICAL HISTORY FORM

	Tick either 'YES' or 'NO' YES	NO
Are you generally fit and healthy?	☐	☐
DO YOU/HAVE YOU EVER SUFFERED FROM: Rheumatic fever or heart murmur?	☐	☐
Any heart problems – angina, high blood pressure, Heart attack, have a heart pacemaker?	☐	☐
Any chest/breathing problems – asthma, bronchitis, Tuberculosis?	☐	☐
Diabetes?	☐	☐
Epilepsy or fainting attacks?	☐	☐
Hepatitis/ jaundice/ liver or kidney problems?	☐	☐
Creutzfeldt jacob disease?	☐	☐
Any other serious illness injury or operation?	☐	☐
Bleed excessively/ have you ever bled excessively?	☐	☐
Carry any warning cards?	☐	☐
Do you smoke? If so, how many per day?	☐	☐
What is your average weekly alcohol intake in units?	☐	☐
ARE YOU: Allergic to any drugs/ substances (e.G. Penicillin, latex)?	☐	☐
Taking any medication (if so please give details)?	☐	☐
Are you taking steroids/ have taken steroids in the last Two years?	☐	☐
Attending your doctor or any hospital specialists?	☐	☐

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