

THE BUSH DENTAL CLINIC

278 Uxbridge Road, Shepherds Bush, London, W12 7JA



MEDICAL HISTORY UPDATE

First Name Surname

Address

..... Post Code

Home Telephone Mobile Email

Next of Kin (Name) (Telephone)

Please circle Yes or No

Have you been seen by your GP during the past year? Yes/No

- If so what was the visit for.....

Are you taking any medication? Yes/No

- If so what
(You may continue on the back or attach a copy of medication)

Have you ever had surgery or radiation therapy? Yes/No

Do you have a heart murmur? Yes/No

Have you had any of the following:-

- | | | | |
|-----------------------------|--------|--|--------|
| • Rheumatic fever | Yes/No | • Congenital heart lesion/cardiac pacemaker | Yes/No |
| • Heart Attack/Angina | Yes/No | • High or Low Blood pressure | Yes/No |
| • Diabetes- Low blood sugar | Yes/No | • Hiatus hernia/Stomach trouble | Yes/No |
| • Epilepsy | Yes/No | • Jaundice, infective hepatitis, Liver disease | Yes/No |

Have you ever had serious bleeding problems after an extraction? Yes/No

Do you have any sinus problems? Yes/No

Do you have Asthma or Hay fever? Yes/No

Do you have any allergies or have you had an allergic reaction to any Medication?

-If yes what.....

Do you have any blood disorders? Yes/No

Have you received any blood transfusions or surgical treatment abroad? Yes/No

Do you suffer from Aids, or are you a HIV carrier? Yes/No

Do you smoke? Yes/No

-If so how many per day.....

Do you drink any alcohol? Yes/No

-If so how many units per week.....

Are you pregnant or had a baby in the last year? Yes/No - Date

GP Details (Mandatory)

Name

Address..... Tel.....

Patient Signed Name in Capitals..... Date

Dentist signature Date

Please note, we are now going to be contacting patients via email or SMS. If you do not want to be contacted in these ways please tick the box.