South Bank Dental Care

SOUTH BANK DENTAL CARE

MEDICAL FORM *All information is strictly confidential*

PERSONAL DETAILS:

Title: ______________________

First Name(s): ______________________ Last name: ______________________ Date of birth: __________

Home address: ____ Post code: __________

Mobile No: ______________ Home No: ______________ Work No: ______________

Occupation: ______________________ E-mail: ______________________

MEDICAL QUESTIONNAIRE:

Name, address and phone number of General Medical Doctor: ______________________

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Are you receiving any medical treatment from the Doctor, Hospital or Clinic? **Yes** **No** If **Yes** please give details: ______________________

____

If you have had any of the following conditions please *circle* **YES** Or **NO.**

Asthma	Yes	No	Stroke	Yes	No	Arthritis	Yes	No
Heart attack	Yes	No	Rheumatic fever	Yes	No	Joint replacement or other implant	Yes	No
Heart disease, heart murmur, heart problem	Yes	No	Liver disease / Jaundice	Yes	No	HIV/Aids	Yes	No
Kidney Disease	Yes	No	Diabetes	Yes	No	Sinus problems	Yes	No
High blood pressure	Yes	No	Tuberculosis	Yes	No	Hepatitis	Yes	No
Brain or heart surgery	Yes	No	Epilepsy	Yes	No	Bronchitis, chest problems	Yes	No
Replacement heart valve	Yes	No	Do you carry a warning card? (Anticoagulants)	Yes	No	Have you ever had blood refused by the Blood Transfusion Service?	Yes	No
Have you ever had a bad reaction to a local or general anaesthetic?	Yes	No	Do you bruise easily or suffer with persistent bleeding following tooth extraction or injury or does anyone in your family?	Yes	No	Do you have fainting attacks, giddiness, blackouts or epilepsy?	Yes	No
Do you have cancer or ever had cancer? If yes which one?	Yes	No	Do you have osteoporosis?	Yes	No			

Have you ever been hospitalised for any reason? ______________________

Any other serious illness: ______________________

Are you pregnant or a nursing mother? **Yes** **No** If **Yes** please give due date/date of baby's birth

____

Do you take contraceptive pills? Yes No

Are you allergic to Penicillin? Yes No — If **Yes** please give details:________________

Are you allergic to any medicines, foods or materials Yes No — If **Yes** please give details:________________

Please Turn Over this page……PTO…………PTO…………PTO…………

Are you allergic to Latex? Yes No

Do you have hayfever Yes No

Do you have eczema? Yes No

Do you smoke? Yes No — If **Yes** average per week:________________

Do you use chewing tobacco? Yes No — If **Yes** average per week:________________

What is your weekly consumption of alcohol in units per week ? ________________

Are you taking any medication, tablets, drugs or injections or using any creams, ointments or inhalers? **Yes** **No**

If **Yes** please give details ________________

Is there anything else about your health you think we should know about?

____

If you are unsure of any of the questions, or if your medical circumstances change, please inform your Dentist.

Do you have:-

Learning Disability	Yes	No	Visual impairment	Yes	No
Hearing Impairment	Yes	No	Mobility impairment	Yes	No

Patient agreement

During a medical emergency where I am unable to speak for myself, I hereby give my permission for the staff to contact ________________ (Name) on ________________ (Telephone number)

Patient Signature:________________ **Date:**________________

Translation and interpreting service

At present, at South Bank Dental Care we can speak the following languages: English, Hindi, Nepalese, Romanian.

It is always advisable to bring with you someone who can speak English or any of the above languages so that we can explain your dental needs to them and they can translate for you as necessary.

Southwark Council also provide a translation service and a telephone interpreting service and you should call 0207 525 5000 to find out more.

Please check that all the information in this form is still correct.

Record the review plus any changes below.

Date of review	Changes advised	Patient signature:
Any changes		Dentist signature:
Yes No		

Date of review	Changes advised	Patient signature:
Any changes		Dentist signature:
Yes No		