

FAIRVIEW DENTAL CLINIC – MEDICAL HISTORY FORM

SURNAME..... FIRST NAME.....

ADDRESS..... TEL (H) (M).....

..... EMAIL ADDRESS.....

D.O.B..... DOCTOR.....

ARE YOU UNDER ANY MEDICAL CARE AT PRESENT.....

ARE YOU TAKING BISPHOSPHONATES e.g. FOSAMAX, ACTONEL, BON VIVA.....

ARE YOU TAKING OR HAVE YOU TAKEN STEROIDS IN THE PAST TWELVE MONTHS

ARE YOU TAKING ANY OTHER DRUGS/MEDICINES AT PRESENT IF SO STATE NAME OF MEDICATION.
PLEASE INCLUDE CONTRACEPTIVES & BLOOD THINNERS.....

HAVE YOU EVER HAD ANY UNUSUAL RESPONSE TO ANY DRUG.....

HAVE YOU EVER HAD ANY ILLNESS WHICH REQUIRED ADMISSION TO HOSPITAL OR A
LENGTHY STAY IN BED – GIVE DETAILS.....

HAVE YOU EVER HAD SEDATION OR A GENERAL ANAESTHETIC.....

DO YOU SNORE OR ARE YOU PRONE TO DAYTIME SLEEPING.....

WERE YOU BORN WITH A HEART DEFECT OR HEART MURMUR.....

HAVE YOU EVER HAD RHEUMATIC FEVER.....

HAVE YOU EVER HAD A HEART ATTACK

HAVE YOU EVER HAD INFECTIVE ENDOCARDITIS (INFECTION OF THE HEART).....

HAVE YOU EVER HAD A CARDIAC (HEART) PROSTHETIC VALVE PLACED

DO YOU SUFFER FROM HIGH OR LOW BLOOD PRESSURE.....

DO YOU SUFFER FROM ASTHMA, HAY-FEVER, OR ALLERGIES

DO YOU SMOKE.....

NUMBER OF UNITS OF ALCOHOL CONSUMED PER WEEK.....

DO YOU TAKE RECREATIONAL DRUGS.....

DO YOU SUFFER FROM FAINTING ATTACKS, FITS OR BLACKOUTS.....

HAVE YOU EVER SUFFERED FROM JAUNDICE OR LIVER DISEASE

HAVE YOU EVER HAD ANY BLOOD BORNE INFECTIONS (eg HEP B, HEP C, HIV).....

HAVE PREVIOUS DENTAL EXTRACTIONS BEEN DIFFICULT.....

HAVE YOU EVER HAD EXCESSIVE BLEEDING AFTER EXTRACTIONS

DO YOU HAVE DIABETES, ARTHRITIS

ARE YOU PREGNANT.....

PATIENT'S SIGNATUREDATE.....

PRSI/ DTBS PATIENTS

**I CONSENT TO ALLOW MY PPS NUMBER TO BE CHECKED ON AN ONGOING BASIS TO
ENSURE I AM QUALIFIED FOR DENTAL TREATMENT**

PATIENT'S SIGNATURE.....