Rectory House
Dental Practice

Medical History

PATIENT DETAILS

Surname (Mr/Mrs/Miss/Ms) _____ Doctor's Name and Address

Forname _____ _____

Address _____ _____

_____ Postcode _____ _____

Tel. No (Home) _____ Tel. No (Mobile) _____ _____

Date of Birth _____

ALLERGIES

Do you have any allergies? Yes ☐ No ☐

If Yes, please specify _____

MEDICAL CONDITIONS

Do you have any of the following conditions Yes ☐ None of the below ☐

If Yes, please tick the condition(s) below that apply to you:

ADHD ☐
Asthma ☐
Anaemia ☐
Anxiety, Mood Swings, Panic Attacks or Depression ☐
Arthritis ☐
Autism ☐
Bipolar ☐
Blood or Bleeding Disorder ☐
Broken Bones ☐
Bronchitis or other Chest Complaint ☐
Cancer ☐
Carry a Medical Warning Card or Bracelet ☐
Cochlear Implant ☐
Communication Difficulties ☐
Diabetes ☐
Eating Disorders or Weight Issues ☐
Eczema ☐
Endocrine Disorder ☐

Fainting Spells, Dizziness or Vertigo ☐
Gallbladder Disease eg. Gallstones ☐
Glaucoma ☐
Gout ☐
Hearing Impairment ☐
Heart Condition, including Heart Murmur ☐
High Cholestrol ☐
High Triglycerides ☐
High or Low Blood Pressure ☐
Infectious Disease (including HIV and Hepatitis) ☐
Kidney Disorder ☐
Learning Disability ☐
Neuromuscular Disorder ☐
Liver Disease ☐
Migraine or Chronic Headache ☐
Mobility Issues ☐
Pacemaker ☐
Pregnant or Possibly Pregnant ☐

Continue to page 2

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MEDICAL CONDITIONS continued

Do you have any of the following conditions Yes ☐ None of the below ☐

If Yes, please tick the condition(s) below that apply to you:

Receiving Treatment from Hospital Doctor or Clinic ☐
Shortness of Breath ..... ☐
Sinus Problems ..... ☐
Skin Condition ..... ☐
Sleep Problems ..... ☐
Speech Impairment ..... ☐

Stomach or Intestinal Problems..... ..... ☐
Taking Any Prescribed / Non Prescribed Medication ☐
Thyroid Disorder ..... ☐
Undergone an Operation in the Last Two Years ..... ☐
Visual Impairment ..... ☐
Any Other Condition Not Listed on Page 1 or 2 .... ☐

Please specify: _____

_____

Additional Notes (optional):

_____

_____

_____

_____

_____

I confirm the contents of this Medical History are correct

Patient's Signature _____ Date _____

Thank you for completing our form