PAISLEY DENTAL CLINIC
39 HIGH STREET
0141 8879 270
SC482143

Confidential Medical History Form

We ask you for information about your general health to help us treat you safely. All information will be kept strictly confidential by the people caring for you.

Title: _____ Full Name: _____ DOB: _____

Address: _____ Postcode: _____

Contact Number: _____ Email address: _____
Occupation: _____

In the event of an emergency, please contact: _____

GP Practice Name & Address: _____

GP Practice Contact Number: _____

Are you Currently?

	Y	N	Give Details
Receiving any treatment from a doctor, hospital or clinic?			
Do you hold a DNAR form? (If yes, please show the form to the dentist			
Taking any prescribed medicines? (tablets, ointments, injections, inhalers)			
Carrying a medical warning card?			
Pregnant or possibly pregnant?			
Allergy to Medicines(Penicillin), Substances or food?			
Bronchitis, Asthma or other chest conditions?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart Problems (Angina, Blood Pressure problems or Stroke)?			
Diabetes?			
Bone or Joint Disease?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Liver disease (jaundice, hepatitis) or Kidney disease?			
Any other serious illness or infectious disease?			
Blood refused by the blood transfusion service?			
A bad reaction to general or local anaesthetic?			
Treatment that required you to be in hospital?			
Heart surgery?			

How many

Units of Alcohol do you drink per week? _____ How Many Tobacco products do you smoke per day? _____

Completed by _____ Reviewed by_____Date: _____

Completed by _____ Reviewed by_____Date: _____