Patient ID________ (staff to complete)

Please list all your prescribed medicines?			
Are you receiving treatment from a doctor, hospital or clinic?	Y / N	Do you suffer from fainting, giddiness, blackouts or epilepsy?	Y / N
Have you had treatment that required you to be in hospital?	Y / N	Have you had heart surgery, heart problems, angina, blood pressure problems, or a stroke?	Y / N
Have you any history of Radiotherapy/Chemotherapy?	Y / N	Do you have diabetes (or does anybody in your family)?	Y / N
Are you taking blood thinners?	Y / N	Do you suffer with arthritis?	Y / N
Do you carry a medical warning card?	Y / N	Have you had rheumatic fever or chorea?	Y / N
Are you pregnant?	Y / N	Do you have any liver or kidney disease?	Y / N
Do you have any allergies to any medicines, substances or food?	Y / N	Have you had a joint replacement or other implant?	Y / N
Have you ever had a bad reaction to a general or local anaesthetic?	Y / N	Have you had any infectious diseases such as HIV, Hep A,B or C or other serious illness?	Y / N
Have you ever suffered from bruising or persistent bleeding following an injury, tooth extraction or surgery?	Y / N	Have you ever had blood refused by Blood Transfusion Service?	Y / N
Do you suffer hay fever or eczema?	Y / N	Do you smoke tobacco products now (or in the past)?	Y / N
Do you suffer bronchitis, asthma or other chest condition?	Y / N	How many units of alcohol do you have in a week?	Y / N
Do you use a fluoride toothpaste?	Y / N	Do you have sugary snacks between meals?	Y / N
Do you clench or grind your teeth?	Y / N	Do you drink fizzy drinks, acidic fruit juices or take sugar in hot drinks?	Y / N
Other information			
Signed		Date	