Bath Street Dental Practice

6 Bath Street
Abingdon
OX14 3QH
01235 520101

Personal Details:		
Patient Name: ______________	DOB: ________	Home Tel: ________
		Mobile Tel: ________
Address: ______________		
______________	Postcode: ________	

Do you have or have you suffered from :- (please tick as appropriate)

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Rheumatic Fever			Pacemaker			Epilepsy			Diabetes		
Heart Problems			Liver or Kidney Disease			Asthma			Allergy to any medicines Eg Penicillin		
Heart Murmur			Jaundice			Chest Problems			Allergies (including Latex)		
High Blood Pressure			Hepatitis			Hayfever			Bleeding Disorder		
Heart Surgery			Blackouts/ Fainting Attacks/ Giddiness			Have you ever been on tablets for Cancer or Osteoporosis?			Have had or are a carrier of a blood borne virus? Eg HIV/Hepatitis		

Please delete as appropriate

Bad reaction to a general anaesthetic? **Yes / No**

Bad reaction to a local anaesthetic? **Yes / No**

Have you been in hospital for any operations/serious conditions in the last 5 years? **Yes / No**

Taken steroids in the last 2 years? **Yes / No**

Do you carry a warning card? **Yes / No**

If female, are you or do you think you may be pregnant **Yes / No**

Are you seeing a doctor at present? **Yes / No**

Had a joint replaced? **Yes / No**

Have used needle delivered recreational drugs? **Yes / No**

Any pills/medication? (please list) **Yes / No**

If yes to any of the above, please give information: ______________

Do you smoke? **Yes / no** (If **yes**, how many smoked per day ______ how many years ______ Previously smoked? **Yes / no**

How many units of alcohol do you drink per week? ______________

How many times per day do you brush your teeth? ______ Are you using fluoridated toothpaste? (eg. Colgate) ______

Use Floss (or any other products for cleaning in-between your teeth)? **Yes/no** If yes, please state how often ______

Name and address of your doctor: ______________

____

Patient (or Parent/Guardian) signature: ______________ **Date:** ______________