CONCORDIA
dental healthcare

Surname (Mr/Mrs/Miss/Ms) .....
Forenames .....
Address .....
..... Postcode .....
Tel No (Home) .....Tel No (Mobile) .....
Date of Birth ..... Occupation .....
Email Address .....

Please complete this form by ticking the appropriate boxes and answering the questions

All details will be strictly confidential

Do you have or have you ever suffered from:	Yes	No
Allergies?	☐	☐
Asthma?	☐	☐
Rheumatic Fever?	☐	☐
High or low blood pressure?	☐	☐
Fainting or dizzy spells?	☐	☐
Jaundice?	☐	☐
Epilepsy?	☐	☐
Diabetes?	☐	☐
Excessive Bleeding?	☐	☐
Any heart or chest complaint, heart surgery or stroke?	☐	☐
Are you attending or waiting to attend a doctor, specialist or hospital as an in-patient or out-patient?	☐	☐
Have you ever been in contact with any viruses, e.g. Hepatitis B or HIV?	☐	☐
Have you had any adverse reactions to local anaesthetic or any dental procedure?	☐	☐
Have you ever experienced hives, asthma or hay-fever symptoms from latex gloves?	☐	☐
Were you treated with human growth hormone prior to 1987?	☐	☐
Have you ever had a Dura Mater graft or brain surgery?	☐	☐
Is there a family history of CJD?	☐	☐
Do you carry a medical warning card?	☐	☐
Are you pregnant?	☐	☐
Are you at present taking any medicine, tablets or creams?	☐	☐
How many units of alcohol do you consume on average per week?	☐	☐
If you smoke how many on average do you smoke per day?	☐	☐
Is there any further information that you feel may be oh help?	☐	☐

If yes to any question please supply details in the notes below or use the back of the form

Notes .....
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Date ..... Patient Signature .....

Date ..... Dentist Signature .....