# SOUTH BANK DENTAL CARE

**MEDICAL FORM** *All information is strictly confidential*

**PERSONAL DETAILS:**

Title: _____

First Name(s):_____ Last name:_____ Date of birth:_____

Home address:_____ Post code: _____

Mobile No:_____Home No:_____Work No:_____

Occupation:_____E-mail:_____

**MEDICAL QUESTIONNAIRE:**
Name, address and phone number of General Medical Doctor:_____
_____

Are you receiving any medical treatment from the Doctor, Hospital or Clinic? **Yes** **No** If **Yes** please give details:_____
_____

If you have had any of the following conditions please *circle* **YES** Or **NO.**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Asthma | **Yes** | **No** | Stroke | **Yes** | **No** | Arthritis | **Yes** | **No** |
| Heart attack | **Yes** | **No** | Rheumatic fever | **Yes** | **No** | Joint replacement or other implant | **Yes** | **No** |
| Heart disease, heart murmur, heart problem | **Yes** | **No** | Liver disease / Jaundice | **Yes** | **No** | HIV/Aids | **Yes** | **No** |
| Kidney Disease | **Yes** | **No** | Diabetes | **Yes** | **No** | Sinus problems | **Yes** | **No** |
| High blood pressure | **Yes** | **No** | Tuberculosis | **Yes** | **No** | Hepatitis | **Yes** | **No** |
| Brain or heart surgery | **Yes** | **No** | Epilepsy | **Yes** | **No** | Bronchitis, chest problems | **Yes** | **No** |
| Replacement heart valve | **Yes** | **No** | Do you carry a warning card? (Anticoagulants) | **Yes** | **No** | Have you ever had blood refused by the Blood Transfusion Service? | **Yes** | **No** |
| Have you ever had a bad reaction to a local or general anaesthetic? | **Yes** | **No** | Do you bruise easily or suffer with persistent bleeding following tooth extraction or injury or does anyone in your family? | **Yes** | **No** | Do you have fainting attacks, giddiness, blackouts or epilepsy? | **Yes** | **No** |

Have you ever been hospitalised for any reason?_____
Any other serious illness:_____

Are you pregnant or a nursing mother? **Yes** **No** If **Yes** please give due date/date of baby's birth
_____

Do you take contraceptive pills? **Yes** **No**
Are you allergic to Penicillin? **Yes** **No** If **Yes** please give details:_____
Are you allergic to any medicines, foods or materials **Yes** **No** If **Yes** please give details:_____

***Please Turn Over this page……PTO……PTO……PTO……***

Are you allergic to Latex? **Yes** **No**
Do you have hayfever **Yes** **No**
Do you have eczema? **Yes** **No**

Do you smoke? **Yes** **No** If **Yes** average per week:_____
Do you use chewing tobacco? **Yes** **No** If **Yes** average per week:_____
What is your weekly consumption of alcohol in units per week ? _____

Are you taking any medication, tablets, drugs or injections or using any creams, ointments or inhalers? **Yes** **No**
If **Yes** please give details _____
_____
_____

Is there anything else about your health you think we should know about?
_____

If you are unsure of any of the questions, or if your medical circumstances change, please inform your Dentist.

**Do you have:-**

| | | | | | |
|---|---|---|---|---|---|
| Learning Disability | Yes | No | Visual impairment | Yes | No |
| Hearing Impairment | Yes | No | Mobility impairment | Yes | No |

**Patient agreement**
During a medical emergency where I am unable to speak for myself, I hereby give my permission for the staff to contact _____ (Name) on _____(Telephone number)

**Patient Signature:_____Date:_____**

## Translation and interpreting service

At present, at South Bank Dental Care we can speak the following languages: English, Arabic, French, Greek, Hindi, Kurdish, Nepalese, Persian (Farsi), Portugese, Romanian, Urdu.

It is always advisable to bring with you someone who can speak English or any of the above languages so that we can explain your dental needs to them and they can translate for you as necessary.

Southwark Council also provide a translation service and a telephone interpreting service and you should call 0207 525 5000 to find out more.

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**Please check that all the information in this form is still correct.**

Record the review plus any changes below.

| Date of review | Changes advised | Patient signature: |
|---|---|---|
| Any changes | | Dentist signature: |
| Yes No | | |

| Date of review | Changes advised | Patient signature: |
|---|---|---|
| Any changes | | Dentist signature: |
| Yes No | | |

| Date of review | Changes advised | Patient signature: |
|---|---|---|
| Any changes | | Dentist signature: |
| Yes No | | |