Name: Date of birth

ARE YOU CURRENTLY:	NO	YES	IF YES, PLEASE GIVE DETAILS
Pregnant ?			
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines, tablets etc. including contraceptive pill? Taking (or taken) bisphosphonates			
Carrying a warning card?			

DO YOU SUFFER FROM:	**NO**	**YES**	**IF YES, PLEASE GIVE DETAILS**
Allergies to any medicines (e g antibiotics), or substances (e g latex)?			
Hay fever, eczema or asthma?			
Epilepsy, fainting attacks or blackouts?			
Diabetes, or does anyone in your family?			
Arthritis?			
Bruise easily or bleed excessively following any injury or tooth extraction?			
Any infectious diseases (including HIV or hepatitis)			

DID YOU, AS A CHILD OR SINCE, HAVE	**NO**	**YES**	**IF YES, PLEASE GIVE DETAILS**
Rheumatic fever			
Liver disease (e g jaundice, hepatitis) or kidney disease?			
Asthma, or any other chest disease or condition?			

DID YOU, AS A CHILD OR SINCE, HAVE	**NO**	**YES**	**IF YES, PLEASE GIVE DETAILS**
Blood tests or blood diseases? Ever had blood refused for a transfusion			
Bad reaction to general or local anaesthetic?			
Take steroids (past or present)			
Taken recreational drugs?			

	NO	YES	IF YES, PLEASE GIVE DETAILS
Suffered Osteoporosis? Or taking (taken) bisphosphonates?			
Treatment requiring you to go into hospital?			
Heart problems, angina, high/low blood pressure, suffered heart attack or stroke?			
Heart valve replaced or damage?			
Pacemaker fitted?			
Heart murmur?			
Organ transplant?			
Immunity Suppression?			

As part of our monitoring of your general health and risk of certain illnesses such as oral cancer we would be obliged if you could answer these basic lifestyle questions:

DRINKING	GIVE DETAILS
How many units of alcohol do you drink per week? (A unit is half a pint of lager, a single measure of spirits or a single glass of wine)	

SMOKING AND CHEWING	NO	YES	IN PAST	QUANTITY PER DAY
Do you smoke any tobacco products now or in the past?				
Do you chew tobacco now or in the past?				

Doctors Name & Address

Doctors Tel no

Signature:

Date:

Completed by: Self / Parent / Guardian (please circle)