<table>
<tr><td colspan="5">Sleaford Smile Centre Medical History From</td><td> </td></tr>
<tr><td colspan="5">Full Name</td><td></td></tr>
<tr><td colspan="2">Date of Birth</td><td></td><td>Title</td><td colspan="2">Mr/Mrs/Miss/Ms/Dr/other please state other</td></tr>
<tr><td colspan="6">Address</td></tr>
<tr><td colspan="6">Postcode</td></tr>
<tr><td rowspan="3">Tel</td><td>Home</td><td colspan="4"></td></tr>
<tr><td>Work</td><td colspan="4"></td></tr>
<tr><td>Mobile</td><td colspan="4"></td></tr>
<tr><td colspan="2">E-Mail address</td><td colspan="4"></td></tr>
<tr><td colspan="2">☐</td><td colspan="4">Tick box left, if you are not happy to receive practice communications</td></tr>
<tr><td colspan="2">Name of GP/Dr</td><td></td><td>Next of Kin</td><td colspan="2">☐</td></tr>
<tr><td colspan="2">GP Practice address</td><td></td><td>Next of Kin: Contact Number</td><td colspan="2"></td></tr>
<tr><td colspan="2">Occupation</td><td></td><td colspan="2">Please notify the dentist if you are, or may be, pregnant</td><td>Expected Delivery Date:</td></tr>
</table>

** By ticking the box above I understand that in the event of an emergency I hereby give permission for a member of staff to contact my next of kin. To ensure we continually offer you specific treatment options you will be required to review and sign this form at start of every treatment or emergency appointment*

Please keep us informed of any changes in your medical history.

Signed	Dated	Signed	Dated
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Please turn over the page

Have you ever had or suffer from any of the following;

Condition	Yes	No	Detail
Any Heart Complaints	Yes	No	If Yes please detail
Rheumatic Fever	Yes	No	If Yes please detail when
Chest Problems	Yes	No	If Yes please detail
Diabetes	Yes	No	If Yes please detail Type 1 or 2
High/Low Blood Pressure	Yes	No	If Yes please sate & detail
Jaundice/Hepatitis	Yes	No	If Yes please detail when
HIV/AIDS	Yes	No	If Yes please detail
Epilepsy	Yes	No	If Yes please detail last episode
Excessive Bleeding or Bruising	Yes	No	If Yes please detail
Gastro Intestinal Condition ie Colitis	Yes	No	If Yes please detail
Have you taken steroids in the last 2 years	Yes	No	If Yes please state when
Do you have a history of any cancer or currently have cancer	Yes	No	If yes please state detail
Do you have any physical impairments	Yes	No	If yes please detail
Do you have any special needs	Yes	No	If yes please state
Have you had any blood tests within the last 2 years	Yes	No	If yes please detail
Do you have any allergies ie latex, peanuts etc	Yes	No	If yes please state clearly
Have you taken any medication recently or currently on a course of medication	Yes	No	If yes please detail
Are you pregnant	Yes	No	Due Date:
Do you smoke	Yes	No	If yes how may daily
Do you drink	Yes	No	If yes how many units weekly

Is there anything else not mentioned above

Please detail any further medications currently taken;

It is important your medical history remains up-to date. Please ansure you advise us of any changes. Thank you