apple dental practice

Name **Date of birth:-**

Confidential Medical History

GP's name:-
GP Address:-

Emergency contact details
Name:-
Phone number:-

1. Have you ever had or do you suffer from any of the following?

Heart disorders	Yes / No	Previous General Anaesthesia/Sedation	Yes / No
Chest problems e.g. asthma/bronchitis	Yes / No	Are you patient pregnant/ breastfeeding	Yes / No
High Blood Pressure	Yes / No	Do you use recreational drugs/narcotics?	Yes / No
Kidney or Liver disease	Yes / No	Infections such as HIV/ Hep B	Yes / No
Diabetes / Endocrine disorders	Yes / No	Joint disorder	Yes / No
Epilepsy/Fainting attacks	Yes / No	Neurological problems	Yes / No
Bleeding disorders	Yes / No	Do you carry a warning card	Yes / No
Disabilities or Learning difficulties	Yes/ No	Any other serious illness /operation?	Yes/ No

If yes to any of the above please give details:

2. Allergies

3. Current Medication

Signature Date