Smilescene Medical History Form

(All information given in this questionnaire is strictly confidential and will form part of your medical history)

Title:	Other
Forename:	
Surname:	
D.O.B (dd/mm/yyyy):	

Address:	
Postcode	
Occupation:	
Contact Number:	

Doctor's Name:	
Doctor's Address:	
Doctor's Number	

Do you have, or have you, ever been affected by the following:	Yes:	No:	Details:
COPD, Asthma or any other Respiratory Disease?			
Diabetes? (specify if any family history)			
Epilepsy, Blackouts or Fainting?			
Jaundice, Liver or Kidney Disease?			
Excessive Bleeding or Bleeding Disorder?			
High Blood Pressure?			
Heart Disease, Heart Attack or Related Complaint?			
Have you ever had Heart Surgery?			
Arthritis?			
Joint Replacement Surgery?			
Have you received Steroid Therapy within the last 2 years?			
Do you suffer from Cold Sores?			
Are you HIV Positive?			
Do you have Hepatitis?			
Have you had recent Blood tests? (please explain)			
Has a Blood donation ever been refused?			
Undergone Hospitalisation that may affect Dental Care?			
Do you have a Serious Illness or Medical Condition?			
Are you currently undergoing any Medical Treatment?			
Do you suffer from any allergies to Medication or Tablets?			
Do you have any other allergies?			
Do you drink alcohol? If yes, how many units per week?			
Do you smoke? If yes, how many per day?			
Would you like a referral for Smoking Cessation treatment?			
If applicable, are you pregnant? (please include your due date)			
Have you had a child in the last 12 months?			
Are you currently Breastfeeding?			
Are you currently taking any Medications (including the contraceptive pill)? Please list each Medication and the corresponding dose			

Patient Signature:		Date:	

Once you have completed this form please email it to: SmilesceneMedicalHistories@gmail.com

Submit