Crown Dental Group : Medical History

Patient Name: ..... Date of Birth: .....

GP's Name and Practice: .....

Have you ever had the following? (please delete as appropriate)

1. Do you have any allergies? Yes/No
Please state: .....
.....
.....

2. Heart Problems Yes/No
Please specify: .....
.....
.....

3. Rheumatic fever Yes/No
4. High Blood Pressure Yes/No
5. Stroke Yes/No
6. Blood disorders or prolonged bleeding Yes/No
7. Lung Disease Yes/No
8. Asthma Yes/No
9. Sinus problems Yes/No
10. Kidney disease Yes/No
11. Liver disease Yes/No
12. Hormone deficiency (eg thyroid) Yes/No
Please specify:
.....
13. Diabetes Yes/No
14. Digestive disorders Yes/No
15. Arthritis Yes/No
16. Glaucoma Yes/No
17. Osteoporosis Yes/No
18. Epilepsy, convulsions (seizures) Yes/No
19. Neurologic problems Yes/No
20. Cold sores Yes/No
21. Hay fever Yes/No
22. Hepatitis (type.....) Yes/No
23. Tumor, abnormal growth Yes/No
Please specify:
.....
24. Radiation therapy Yes/No
25. Chemotherapy Yes/No
26. Psychiatric treatment Yes/No

Are You:

27. Presently being treated for any other illness Yes/No
Please specify:
.....
28. Currently a smoker or chew tobacco Yes/No
29. Have you ever smoked or chewed tobacco Yes/No
30. Do you use E-cigarettes Yes/No
31. How many units of alcohol do you consume per week? _____
32. Currently/ likely to become pregnant Yes/No
33. **Are you currently taking bisphosphonates** Yes/No

Describe any current medical treatment, impending surgery or other treatment that may possibly affect your dental treatment. .....
.....

List any medication and supplements, including birth control (please ask if you need an additional sheet)

Drug	Purpose	Drug	Purpose
.....	.....	.....	.....
.....	.....	.....	.....

Please advise us of any change in your medical history or any medication you may be taking

Patient's signature..... Date.....
Dentist's signature ..... Date .....
Telephone Number ..... Mobile number .....
How did you hear about us?.....

updated 11/15