Personal details.

Title & Full name:	
Date of birth:	
Home address including postcode:	
Contact number:	
Email address:	
Occupation:	
If you receive an exemption please state which one.	
GP practice:	

Medical history form.

Are you receiving any treatment from your GP or a hospital? If so please explain.	
Are you allergic to anything e.g. foods, materials, medications?	
Are you taking or have you taken any steroids?	
Any current or previous cancer? Did you have any treatment e.g. surgery, chemotherapy or radiotherapy?	
Have you had rheumatic fever?	
Do you have any liver conditions e.g. Jaundice, Hepatitis?	
Do you have any heart conditions e.g. murmur, angina, previous heart attacks, pace makers, artificial valves?	
Do you suffer from high blood pressure?	
Do you have any blood conditions e.g. anemia, haemophilia?	
Do your bruise or bleed easily?	

Have you ever had a bad reaction to local anaesthetic?	
Do you suffer from any infectious diseases e.g. HIV?	
Do you have any joint conditions or replacements e.g. arthritis, osteoarthritis, replacements?	
Do you suffer from any lung conditions e.g. bronchitis, asthma, COPD?	
Do you suffer from blackouts, epilepsy or fainting attacks?	
Do you suffer from diabetes? Is anyone in your family diabetic?	
Are you pregnant or possibly pregnant?	
Do you carry a medical warning card? If so please explain.	
Do you smoke or vape? Present or past? How many per day?	
Do you drink alcohol? Average units per week?	
Our dental chairs have a weight limit of 21 stone 135kg, if you weigh more than this please indicate.	
Please list all medication you take (prescribed and/or over the counter).	

Covid-19 screening form.

Have you received the Covid-19 Vaccination (please circle)		
First Vaccine: YES / NO	Second Vaccine YES / NO	Booster YES/NO
Signature:		
Date:		