Valley Dental
ANGLESEY

Patient Medical Listing

Name	**DOB**
Address:	**Town/City:** **Postcode:**
GP Surgery or Doctor name:	**Email:**
Phone no(Home)	**Phone ne(Mobile)**

Your privacy is our priority. Read our Privacy Policy to find out more.

Question	**Answer**
Are you currently receiving treatment from a doctor, hospital or clinic?	
Are you currently taking any prescribed medicines? (e.g. tablets, ointments or inhalers, including contraceptives and hormone replacement therapy)	
Are you carrying a medical warning card?	
Are you currently pregnant?	
Do you suffer from allergies to any medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods?	
Do you suffer from Hay fever or eczema?	
Do you suffer from bronchitis, asthma or other chest conditions?	
Do you suffer from fainting attacks, giddiness, blackouts or epilepsy?	
Do you suffer from heart problems, angina, blood pressure problems, or stroke?	
Are you diabetic (or is anyone in your family)?	
Do you suffer from arthritis?	
Have you ever had a joint replacement or other implant?	
Do you suffer from bruising or persistent bleeding following injury, tooth extraction or surgery?	
Have you ever had liver disease (e.g. jaundice, hepatitis) or kidney disease?	
Do you suffer from any infectious diseases (including HIV and hepatitis)?	
Have you ever had blood refused by the Blood Transfusion Service?	
Have you ever had a bad reaction to general or local anaesthetic?	
Have you ever had treatment that required you to be in hospital?	
Have you ever had heart surgery?	
Do you regularly drink more than 21 units of alcohol per week?	
Do you smoke any tobacco products now (or did you in the past)?	
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)?	
Have you ever had any other serious illness?	
Do you have any close relatives (parent, sibling, child, grandparent or grandchild) with Creutzfeldt jakob disease?	
Is there any other information which your dentist might need to know about, such as self-prescribed medicines (e.g. aspirin)?	

If anytime the surgery needs to contact you do we have permission to leave a message?

Telephone Yes ☐ **Post** Yes ☐ **Email** Yes ☐ **SMS** Yes ☐

No ☐ No ☐ No ☐ No ☐

Completed by: Self ☐ Parent ☐ Carer ☐

Patient Signature_____ Date_____