Walnut Dental

01908 606106
info@walnuttreedental.co.uk
www.walnuttreedental.co.uk
10 Fyfield Barrow, Walnut Tree, Milton Keynes MK7 7AN

Confidential Medical History

Mr/Mst/Mrs/Miss/Ms/Other: Date Of Birth:

Surname: Occupation:

First Name: Address:

NHS Number (if known):

Email: Post Code:

Home Tel: Work Tel: Mobile:

Next Of Kin Name: Next Of Kin Contact Number:

Doctors Name: Doctors Contact Number:

Doctors Address:

Are you happy for us to contact you? YES NO

Have you had your COVID-19 vaccination? YES NO

How long since you last visited a dentist?

If you answer YES to any of the questions below, please give details.....extra space on reverse

Are You:	Yes	No
An expectant Mother?		
Attending or receiving treatment from a Doctor, Hospital, Clinic or Specialist? If yes, what for:		
Taking any medicines from your Doctor? (Tablets, creams, ointments, injections etc.) If yes, what:		
Taking or have taken Steroids in the last two years?		
Allergic to any medicines food or materials?		

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Have You:	Yes	No
Had rheumatic fever or Chorea (St. Vitus Dance?)	☐	☐
Had jaundice, liver, kidney disease, hepatitis, HIV or AIDS? Other? If yes, what	☐	☐
Had a heart murmur or heart problem, angina, blood pressure or heart attack?	☐	☐
Had any blood tests or inoculations?	☐	☐
Ever had your blood refused by the Blood Transfusion Service?	☐	☐
Had a bad reaction to a general or local anaesthetic?	☐	☐
Been hospitalised? If so, what for and when?	☐	☐

Do You:	Yes	No
Have a pacemaker, or have you had any form of heart surgery?	☐	☐
Suffer from hay fever, eczema or any other allergy?	☐	☐
Suffer from bronchitis, asthma or any other chest condition?	☐	☐
Have fainting attacks, giddiness, black outs or epilepsy?	☐	☐
Have diabetes, or does anyone in your family?	☐	☐
Bruise easily, or do you or your family bleed so as to cause you to be worried? Carry a warning card?	☐	☐
Are there any other health issues that you think the dentist should know about? If so, what:	☐	☐
Are you a smoker?	☐	☐
Do you drink alcohol? If yes, which of the following: 6 units per week ☐ 12 untis per week ☐ 18 units per week ☐ 22+ units per week ☐	☐	☐

Completed By: Self ☐ Parent ☐ Guardian ☐ Please Print Name If Not The Patient:

Date: Signature:

Please check for changes, resign and date on the next page every 6 months.

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Please check for changes, resign and date

Date: Signature:

Date: Signature:

Date: Signature:

Any other notes/minor ammendments:

Nurses use only: temperature