MINT
DENTAL HYGIENE

	Medical history- add any details at end or back of form	Tick if yes
1	Do you have any allergies?	
2	Do you have a pacemaker, heart murmur, angina, had any form of heart surgery or any other heart problem?	
3	Have you had Jaundice, liver, kidney disease or hepatitis?	
4	Please tick if you have any blood born viruses including H.I.V. Hep C etc	
5	Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?	
6	Are you taking any medicines from your doctor? (Tablets, creams, ointments, injection, contraceptive pill, other)	
7	Have you had a bad reaction to a local Anaesthetic?	
8	Have you taken steroids in the last 2 years?	
9	Have you had a joint replacement?	
10	Do you carry a warning card?	
11	Are you diabetic?	
12	Do you have Epilepsey?	
13	Do you have any other medical condition not mentioned?	
14	Are you a smoker?	
15	How many units of alcohol do you consume on average per week? 1/2 pint beer/lager = 1 unit 1 small glass wine = 1 unit	
16	Are you Pregnant?	
17	Do you have any special communication requirements?	

Doctor Name		Practice	
Emergency Contact		Number	
Details			

Please read and check your medical history. If there have been any changes please amend and add Y (Yes)

Date	Patient Signature	Clinician Signature	Changes updated