



<b>Have you had:-</b>	<b>Yes</b>	<b>No</b>	<b>Give Details</b>
Blood Transfusion?			
A reaction to local or general anaesthetic?			
A joint replacement or other implant?			
Under medical investigation?			
Any other serious illnesses not mentioned?			

<b>Drinking</b>	<b>Yes</b>	<b>No</b>	<b>Units per Week</b>
<i>How many units of alcohol do you drink per week? (A Unit is half a pint of beer, a single measure of spirit or glass of wine)</i>			

<b>Smoking and Chewing</b>	<b>Yes</b>	<b>No</b>	<b>In Past</b>	<b>Quantity per Day</b>
<i>Do you smoke/chew any tobacco products or did you in the past?</i>				

**Any cosmetic issues you wish to discuss?**  
 Eg: teeth straightening, whitening, veneers, missing teeth replacement, tidy up

**Completed by: Patient/Parent/Legal Guardian (Please circle)**

**Signature.....Date.....**

**MEDICAL HISTORY UPDATE**

<u>Date</u>	<u>No Changes</u>	List any changes below	<b>Patient/Parent/Guardian</b>

**Medication and Additional Notes**