Friel & McGahon
DENTAL

Title:	Name:		
DOB:	Age:	Sex: ☐ M ☐ F	PPS No. _____
Address:			
Tel No. Home:	Mobile:		Email:
Do you have any Health Insurance?	☐ Yes ☐ No	VHI / BUPA / Garda / ESB Scheme/ Other	
Do you have a Medical Card?	☐ Yes ☐ No	If so , No. _____	
Next of Kin:	Contact No: _____		
Doctor's Name and Address:			
Pharmacy Name and Address:			

	Yes	No
Do you feel healthy?	☐	☐
Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?	☐	☐
Do you have any heart conditions?		
-Congenital heart defect/ heart transplant/ replacement valve/ infective endocarditis	☐	☐
-Angina	☐	☐
-Heart Attacks	☐	☐
-High Blood Pressure	☐	☐
Do you have any chest complaints?		
-Coughs	☐	☐
-Bronchitis	☐	☐
-Asthma	☐	☐
-Other	☐	☐
Have you had jaundice, hepatitis, liver or kidney disease?	☐	☐
Do you have diabetes or does anyone in your family?	☐	☐
Do you suffer from fainting attacks, giddiness, blackouts or epilepsy?	☐	☐
Do you bruise easily or bleed excessively following a cut or tooth extraction?	☐	☐
Do you have arthiritis?	☐	☐

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	Yes	No
Are you receiving any medicines, tablets, creams, ointments, injections from your doctor? If yes, please list: _____	☐	☐
Are you taking bisphosphonates?	☐	☐
Had you had radiotherapy to the head and neck area?	☐	☐
Are you allergic to any medicines, foods or materials (i.e. penicillin, latex, elastoplast, metals, other)	☐	☐
Are you or do you think you could be pregnant?	☐	☐
Are you taking the oral contraceptive pill?	☐	☐
Do you take recreational drugs? E.g. Cocaine, heroin	☐	☐
Are you in a risk group for blood viral infections (ie. Hepatitis B, Hepatitis C, H.I.V. / Aids)?	☐	☐
Have you been hospitalised? If yes, what for and when?	☐	☐
Do you know of any other relevant medical history we have not already covered?	☐	☐

Social History

Do you smoke cigarettes, cigar or pipe? If yes, approximate consumption:	☐	☐
Have you ever smoked? ☐ Yes ☐ No When did you stop?		
Do you consume alcohol? If yes, approximate consumption:	☐	☐

I Certify that the above information is correct: Signature: _____

Date: _____