CONFIDENTIAL MEDICAL HISTORY FORM

Information about your general health is required to help us treat you safely. Please write your contact details below, answer the health questions and then sign the form. All information will be kept strictly confidential by the people caring for you.

TITLE	SURNAME FORENAMES	
DATE OF BIRTH / /	SEX MALE / FEMALE	OCCUPATION
ADDRESS POSTCODE		
PHONE NUMBERS: HOME WORK MOBILE CONSENT FOR TEXT REMINDERS YES / NO EMAIL		
EMERGENCY CONTACT NAME: RELATIONSHIP TO YOU: EMERGENCY CONTACT TEL/ MOBILE:		
HOW LONG IS IT SINCE YOUR LAST DENTAL TREATMENT?		
YOUR DOCTOR'S NAME DOCTOR'S ADDRESS DOCTOR'S PHONE NUMBER		
HOW DID YOU HEAR ABOUT THIS PRACTICE ?		

DRINKING ALCOHOL	**UNITS / WEEK**
How many units of alcohol do you drink per week ? *(A unit is half a pint of lager, a single measure of spirits or a single glass of wine / aperitif)*	

SMOKING AND CHEWING	**YES**	**NO**	**IN THE PAST**	**QUANTITY**
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?)				

	YES	**NO**
One of our dental chairs has a safety limit of 135kg. Please advise if you currently weigh over 135kg (21st 3.6lbs).		
Do you carry a health passport, warning card or other document regarding your health? (Write the details below, if applicable)		
Details:		

	YES	NO	DETAILS
ARE YOU: 1. Attending or receiving treatment from a doctor, hospital, clinic or specialist ?			
2. Taking any medicines from your doctor ? (tablets, ointments, creams, injections, or inhalers, including contraceptives and hormone replacement therapy ?			
3. Taking or have you taken steroids in the last two years ?			
4. Allergic to any medicines eg penicillin, foods or materials eg latex/rubber ?			
5. Pregnant ?			
HAVE YOU: 6. Had rheumatic fever or chorea (St Vitus Dance) ?			
7. Had jaundice, liver or kidney disease or hepatitis ?			
8. Ever been told you have a heart murmur or heart problem, angina, blood pressure, heart attack ?			
9. Ever had your blood refused by the National Blood Transfusion Service ?			
10. Had a bad reaction to a general or local anaesthetic ?			
11. Had a joint replacement ?			
12. Been hospitalised ? If “YES”, what for, and when ?			
13. Had any other serious illness ?			
14. Had radiotherapy to the neck or head area?			
15. Had any infectious diseases including HIV and Hepatitis ?			
DO YOU: 16. Have arthritis?			
17. Have a pacemaker, or have you had any form of heart surgery ?			
18. Suffer from hay fever, eczema or any other allergy ?			
19. Suffer from bronchitis, asthma, other chest condition ?			
20. Have fainting attacks, giddiness, blackouts, epilepsy ?			
21. Have diabetes or does anyone in your family ?			
22. Have a close relative who has or has had CJD (The human form of BSE ?)			
23. Were you treated with growth hormone before the mid 1980s ?			
24. Have you ever had brain surgery ?			
25. Bruise easily, or following a tooth extraction, surgery or injury have you or your family bled so as to cause you to be worried ?			
26. Ever get cold sores ?			
27. Have osteoporosis, and if yes, are you taking medication for this ?			
28. Are there any other aspects concerning your health that you think the dentist should know about ?			
Please give any other details which your dentist might need to know about, such as self-prescribed medicines (eg aspirin)			

Completed by (please tick) Self Parent Guardian Carer

SIGNATURE DATE