

Confidential Medical History Form

We ask you for information about your general health to help us treat you safely. Please write your contact details below, answer the health questions and then sign the form on the back page. We will use this form at later visits to discuss any change in your general health. All information will be kept strictly confidential by the people caring for you.

Completed by (please tick)	self <input type="checkbox"/>	parent <input type="checkbox"/>	guardian <input type="checkbox"/>
Patient signature _____	Date _____		
Dentist signature _____	Date _____		

Medical history update

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

Date	Any changes?	List changes below	Patient initials

Title:	Last name:
First name:	Date of birth: ____ / ____ / ____
Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	School attended:
Address:	Postcode:
Telephone number (home):	Mobile number:
Email:	Occupation:
In the event of an emergency, please contact	
Name:	Relationship to you:
Telephone number:	Telephone number:
Doctor's details	
Doctor's name:	Telephone number:
Address:	Postcode:

Are you currently **yes / no** **give details**

Receiving treatment from a doctor, hospital or clinic?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Taking any prescribed medicines (eg tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Carrying a medical warning card?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pregnant or possibly pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you ever suffered from **yes / no** **give details**

Allergies to medicines (eg penicillin), substances (eg latex/rubber) or foods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bronchitis, asthma or other chest condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fainting attacks, giddiness, blackouts, epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart problems, angina, blood pressure problems, or stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes (or does anyone in your family)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bone or joint disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bruising or persistent bleeding following injury, tooth extraction or surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Liver disease (eg jaundice, hepatitis) or kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any other serious illness or infectious disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you ever suffered from **yes / no** **give details**

Blood refused by the Blood Transfusion Service?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
A bad reaction to general or local anaesthetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Treatment that required you to be in hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Alcohol

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/apertif.)

_____ units per week

Smoking

yes / no / in the past

Do you smoke any tobacco products now (or did you in the past)?

_____ times per day

Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)?

_____ times per day

Please give any other details which your dentist might need to know about, such as self-prescribed medicines (eg aspirin) or any disabilities you may have.