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 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.

Personal Details

Title: _____ Last Name: _____ First Name: _____

Date Of Birth: _____

Sex: Male ___ Female ___

Address: _____

PostCode: _____

Telephone No: _____

Mobile No: _____

Email Address: _____

Occupation: _____

Child Patients - School Attended: _____

Doctors Details

Name: _____

Address: _____

Postcode: _____

Telephone No: _____

In the event of an emergency, please contact:

Name:_____

Telephone Number: _____

Relationship To You: _____

Are you currently:	YES	NO
Receiving treatment from a doctor, hospital or clinic?		
Taking any prescribed medicines (eg tablets, ointments, injections, inhalers, including contraceptives and HRT)		
Carry a medical warning card?		
Pregnant or possibly pregnant?		

Have you ever suffered from:	YES	NO
Allergies to medicines (eg penicillin), substances (eg latex) or food?		
Bronchitis, asthma or other chest conditions?		
Fainting attacks, giddiness, blackouts, epilepsy?		
Heart problems, angina, blood pressure problems or stroke?		
Diabetes? Or does anyone in your family?		
Bone or joint disease?		
Bruising or persistent bleeding following surgery, injury or tooth extraction?		
Liver disease or kidney disease?		
Any other serious illness or infectious disease?		

Have you had:	YES	NO
Blood refused by the Blood Transfusion Service?		
A bad reaction to general or local anaesthetic?		
Treatment that required you to be in hospital?		
Heart Surgery		

Alcohol:

How many units of alcohol do you drink per week? One unit is half a pint of lager, a single measure of spirits or a single glass of wine.

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:**

Further Details:

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

Completed By (please tick) **Self_____Parent_____Guardian_____**

Patient signature_____ **Date_____**

Dentist signature_____ **Date_____**

Medical History Updated:

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 and changes below.

Date	Any changes?	List changes below	Patients initials