CONFIDENTIAL MEDICAL HISTORY

To provide the best and safest treatment, your dentist needs to know of any problems which may affect your treatment.

Surname Mr / Mrs / Miss _____ Sex: Male / Female

Forename(s) _____

Address _____

_____ Postcode _____

Tel: Home _____ Work _____

Mobile _____ Email _____

Date of birth _____ Occupation _____

When did you last receive dental treatment _____

Your doctor's name & address _____

_____

Your N.H.S. No. _____

	YES	NO	IF YES, PLEASE GIVE DETAILS
Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Are you taking any medicines, tablets, drugs or injections or using any creams, ointments or inhalers?			
Are you taking or have you taken steroids in the last 2 years?			
Are you allergic to penicillin?			
Are you allergic to any medicines, foods or materials?			
Do you carry a warning card?			
Are you pregnant or a nursing mother?			
Are you HIV positive?			
Have you had rheumatic fever or chorea?			
Have you had jaundice, liver or kidney disease or hepatitis?			
Have you ever had a Stroke?			
Did you as a child or since have brain surgery, growth hormone treatment before the mid 1980's or have a close relative with Creutzfeldt Jakob Disease?			

Please continue overleaf . . . . .

	YES	NO	IF YES, PLEASE GIVE DETAILS
Have you ever been told you have a heart murmur, heart problem, angina or high blood pressure?			
Have you ever had your blood refused by the Blood Transfusion Service?			
Have you ever had a bad reaction to a local or general anaesthetic?			
Have you had a joint replacement or other implant?			
Have you been hospitalised for any reason?			
Do you have arthritis?			
Do you have a pacemaker or have you had heart surgery?			
Do you suffer from hay fever, eczema, or any other allergy?			
Do you suffer from bronchitis, asthma or other chest condition?			
Do you have fainting attacks, giddiness, blackouts or epilepsy?			
Do you have diabetes or does anyone in your family?			
Do you bruise easily or suffer persistent bleeding following a tooth extraction or injury or does anyone in your family?			
Do you think there are any other aspects, concerning your health, that your dentist should know about?			
On average, how much of the following do you consume per day?	Cigarettes _____		Alcoholic Drinks _____

SIGNED _____ DATE _____

Patient / Parent / Guardian (delete as applicable)

MEDICAL UPDATES - Have there been any changes in your health or medication since your last visit? (Please ensure you amend this form accordingly with any changes)

Date of medical update	Any changes?	Signed by Patient	Acknowledged by Dentist
	Yes ☐ No ☐		
	Yes ☐ No ☐		
	Yes ☐ No ☐		

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