CONFIDENTAL MEDICAL HISTORY

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

Mr/Mrs/Ms/Miss
Name:_____Gender:_____
Address:_____
_____Postcode:_____
Date of Birth: _____Occupation:_____Email:_____
Tel No Home:_____Mobile:_____
When did you last receive dental treatment _____
Your doctor's name, address _____
_____
Next of kin name, address and contact number _____
_____

	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 or contraceptive pill?			**If yes please list in full overleaf**
Are you taking or have you taken steroids or hydro-cortisone in the last 2 years?			
Are you allergic to penicillin?			
Are you allergic to latex?			
Are you allergic to any medicines, foods or materials?			
Do you suffer from hay fever, eczema or any other allergies?			
Are you pregnant or nursing mother?			
Are you HIV positive?			
Have you had rheumatic fever, bacterial endocarditis or chorea?			
Have you had jaundice, liver, kidney disease or hepatitis?			
Have you ever been told you have 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 bad reaction to local or general anaesthetic?			
Have you had a joint replacement or other implant?			
Have you ever been hospitalised for any reason?			
Have you had any operation in the past 2 years?			
Do you have arthritis?			

Do you have pacemaker or have you had heart surgery or stroke?			
Do you suffer from stomach problems or urinary problems?			
Do you have or suffer from bronchitis, tuberculosis, asthma or other chest conditions?			
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 carry a warning card?			
What is your average weekly consumption of alcohol?			
If you smoke, what is your average per day?			
Do you think there are any other aspects concerning your health that your dentist should know about?			

Details of medication

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Signed Patient/parent/guardian/ (delete as applicable) _____Date:_____

Updated on: _____ Signed: _____

Updated on: _____ Signed:_____

Updated on: _____ Signed: _____

Updated on: _____ Signed: _____

Updated on: _____ Signed: _____

Updated on: _____ Signed:_____

Updated on: _____ Signed: _____

Updated on: _____ Signed: _____