Confidential Medical History

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 inside 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.

Surname ____

First names____

Sex Male Female

Date of Birth dd_____mm____yy_____

Address

____

____

____

______________________________ **Post Code**______________

Telephone Home ________________

Work ________________

Email ________________________________

Occupation ________________________________

Doctor's Name and Address

____

____

____

Doctor's Telephone ________________________

Are you Currently **Give Details**

Receiving treatment from a Doctor, hospital or clinic? Yes No ________________________________

____

Taking any prescribed Medicines (eg tablets, Ointments, injections or Inhalers, including contraceptives And hormone replacement therapy? Yes No ________________________________

____

____

____

____

Carry a medical warning card? Yes No ________________________________

Do you suffer from			Give Details
Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?	Yes	No	
Hay fever or asthma?	Yes	No	
Bronchitis, asthma or other Chest condition?	Yes	No	
Fainting attacks, giddiness, Blackouts, epilepsy?	Yes	No	
Heart problems, angina, blood Pressure problems, or stroke?	Yes	No	
Diabetes (or does anyone in Your family)?	Yes	No	
Arthritis?	Yes	No	
Bruising or persistent bleeding Following injury, tooth extraction or surgery?	Yes	No	
Any infectious diseases (Including HIV and hepatitis)?	Yes	No	

Did you, as a child or since, have			Give Details
Rheumatic fever or chorea?	Yes	No	
Liver disease (eg jaundice, hepatitis) Or kidney disease?	Yes	No	
Any other serious illness?	Yes	No	
Blood refused by the Blood Transfusion Service?	Yes	No	
A bad reaction to general or Local anaesthetic?	Yes	No	
A joint replacement or other Implant?	Yes	No	
Treatment that required you to be In hospital?	Yes	No	
Heart Surgery	Yes	No	

Drinking

How many of 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.) ______Units per week

Smoking and Chewing

Do you smoke any tobacco products Now (or did you in the past)?	Yes	No	In Past	______times per day
Do you chew tobacco, pan, use gutkha Or supari now (or did you in the past)?	Yes	No	In Past	______times per day

Please give any other details which your dentist might need to know about, such as self-prescribed Medicines(eg aspirin)

____
____
____
____
____
____
____
____
____
____
____

Completed by (please Circle) Self Parent guardian

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	No Change	List any changes below	Patients initials
________	__________	______________________________	______________
________	__________	______________________________	______________
________	__________	______________________________	______________
________	__________	______________________________	______________
________	__________	______________________________	______________