

Confidential Medical History Form

To obtain the best and safest treatment, please fill these out COMPLETELY.

ARE YOU CURRENTLY:	YES	NO	DETAILS
Attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Taking any medication prescribed by your doctor/hospital? (e.g. Tablets, creams, ointments, injections, Contraceptive pill, HRT)			
Pregnant or a nursing mother			
Carry a medical warning card			
DO YOU SUFFER FROM:	YES	NO	DETAILS
Allergies to any Medicines (e.g. Penicillin), Materials (e.g. Latex) and Food.			
Heart problems e.g. angina, blood pressure problems, heart attack? Please write which one/s			
Difficulty in Swallowing			
Fainting attacks, giddiness, blackouts, or epilepsy			
Bronchitis, Asthma or any other chest condition			
Hayfever or Eczema			
Stomach ulcers/hiatus hernia or indigestion			
Diabetes -Which type and what medication are you taking for it			
Arthritis			
Bruising or persistent bleeding following a tooth extraction, surgery or injury			
Neurological Problems (e.g. Neuropathies, MS etc)			
Muscular Problems (e.g. Myopathy, Dystrophy, Paralysis)			

HAVE YOU HAD	YES	NO	DETAILS
Or noticed any lumps or bumps especially in the Head and Neck region			
Any serious illness requiring you to be hospitalised and if so for what?			
Heart Surgery			
Pacemaker fitted			
Rheumatic Fever, Heart murmur or Chorea?			
Jaundice, Liver, Kidney Disease or Hepatitis			
Had a joint replacement or any other implant/s			
Please tick or TELL THE DENTIST, if you have any blood borne viruses including HIV.			
Are there any other aspects concerning your health that you think your dentist should know about (e.g. CJD, Alzheimer's, Parkinsons')			

SOCIAL HABITS	YES	NO	DETAILS
Do you drink alcohol? How many units of alcohol do you drink per week? ½ pint beer = 1 unit, small glass wine = 1 unit			
Do you smoke any tobacco products (now or in the past). How many a day?			

Signature:

Date:

Next of Kin Name:

Next of Kin Contact Telephone Number:

GP Name and Surgery

