Confidential Medical History Form

We ask you for information about your general health to help us treat you safely. Please fill in your details below, answer the health questions 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.

Surname _____ **Title** _____

First Name(s) _____ **Date of Birth** _____

Your occupation _____

Your GP's Name and Address _____

_____

Are you currently	**Yes**	**No**	**Please give details**
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines ?(eg tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)			
Carrying a medical warning card?			
Pregnant?			
Do you suffer from	**Yes**	**No**	**Please give details**
Allergies to any medicines (eg penicillin) substances (eg latex/rubber) or foods?			
Hay fever or eczema?			
Bronchitis, asthma or other chest condition?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart problems, angina, blood pressure problems or stroke?			
Diabetes (yourself or a blood relative)?			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases (including cold sores, HIV and hepatitis)?			
Have you ever had	**Yes**	**No**	**Please give details**
Rheumatic fever or cholera?			
Liver disease (eg jaundice, hepatitis) or kidney disease?			
Any other serious illness?			

Have you ever had	Yes	No	Please give details
Blood refused by the blood transfusion service?			
A bad reaction to general or local anaesthetic?			
A joint replacement, pacemaker or other implant?			
Treatment that required you to be in hospital?			
Heart surgery?			
Do you	**Yes**	**No**	**Please give details**
How many 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)			Units per week
Do you smoke any tobacco products (or did you in the past)?			Times per day
Do you chew tobacco, pan, use gutka or supari (or did you in the past)?			Times per day
Do you weigh more than 135kg (21 stones)?			Some of the equipment in our practice has weight tolerance limits. If your weight exceeds this limit, alternative arrangements may need to be made for your dental care.

Please give any other details which your dentist might need to know about, such as self-prescribed medicines (e.g. aspirin)

_____

In case of an emergency, please give details of someone who we can contact on your behalf

Name_____ **Relationship**_____

Telephone (inc. dialling code) _____ **Mobile**_____

Completed by (please tick)	Self	Parent	Guardian

Signature_____ **Date** _____

I give my consent to the dentist to request information from my doctor concerning my medical history

Signature_____ **Date** _____

Date	Any change? Yes/No	Please list any changes below	Patient's initials