

Confidential Medical History Form.

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

Title : _____ Name : _____

Date of Birth : _____

Sex : Male / Female

Address : _____

Tel. No : Home _____ Work : _____ Occupation : _____

Expectant Mother : Yes / No

Last Dental Treatment : _____

Doctor's Name and Address : _____

Are you :

	Yes	No	Details
1. Attending or receiving treatment from a doctor, hospital, clinic or specialist ?			
2. Taking any medicines from your doctor ? (Tablets, creams, ointments, injections, other).			
3. Taking or have you taken steroids in the last two years ?			
4. Allergic to any medicines, foods or materials ?			

Have you :

	Yes	No	Details
1. Had rheumatic fever chorea (St Vitus Dance) ?			
2. Had jaundice, liver, kidney disease or hepatitis ?			
3. Informed you have a heart murmur, heart problem, angina, blood pressure, heart attack ?			
4. Had any blood tests, inoculations etc ?			
5. Ever had your blood refused by The Blood Transfusion Service ?			
6. Had a bad reaction to a general or local anaesthetic ?			
7. Had a joint replacement ?			
8. Been hospitalised ? If yes what for and when ?			

Do You :

	Yes	No	Details
1. Have arthritis ?			
2. Have a pacemaker, or any form of heart surgery ?			
3. Suffer from hay fever, eczema or any other allergy ?			
4. Suffer from bronchitis, asthma or other chest infection ?			
5. Have fainting attacks, giddiness, blackouts or epilepsy ?			
6. Have diabetes or does anyone in your family ?			
7. Bruise easily, or following a toothextraction, surgery, or injury, have you or your family bled so as to cause you to be worried ?			
8. Carry a warning card ?			
9. Ever get cold sores ?			

Are there any other aspects of your health that you think the dentist should know about ?

Completed by : Self / Patient / Guardian

Signature :

Date : _____

How did you hear about the practice ? _____ Date : _____