Confidential

Medical History Form

Please provide us with information about your personal details and general health to help us treat you safely. Do not answer any questions you do not understand. You will have the opportunity to discuss any queries with your dentist who will be happy to answer any of your questions. All information will be kept strictly confidential by the people caring for you.

Patient details: (BLOCK CAPITAL LETTERS PLEASE) Title: (Mr/Mrs/Ms/Miss) ....

First Name: ....

Surname: ....

Male: ☐ Female: ☐ Date of birth: (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

Email: ....

Address: ....

Town: ....

Postcode: (ESSENTIAL) .... Telephone: (DAYTIME) ....

NHS Number: ☐☐☐☐☐☐☐☐☐☐ Telephone: (MOBILE) ....

Occupation: ....

Please tick if you would like to receive information about our services, products and information which we feel might be of interest to you by:

Post ☐ Email ☐ Telephone ☐ Text ☐

Next of Kin: (BLOCK CAPITAL LETTERS PLEASE) Title: (Mr/Mrs/Ms/Miss) ....

Contact No: ....

First Name: .... Surname: ....

Relationship to you: ....

Contact Address: ....

By completing this section you consent to the practice contacting your next of kin in the event of a medical emergency

When did you last visit a dentist?: ....

Doctor's Name and Address: ....

Doctor's Telephone: ....

Medical History Update

Please check that the health information on this form is still correct. Please note any changes to your smoking, alcohol or medicine intake and list them in the notes field provided.

Are you currently	Yes	No
Pregnant?	☐	☐
Receiving treatment from a doctor, hospital or clinic?	☐	☐
Taking any prescribed medicines (e.g. tablets, ointments, injections, or inhalers, eyedrops, suppositories, nebulisers, the contraceptive pill or HRT)?	☐	☐
Carrying a medical warning card?	☐	☐

Details:

Do you suffer from	Yes	No
Allergies to any medicines (e.g. penicillin), substances (e.g. latex/rubber or foods)?	☐	☐
Hay fever or eczema?	☐	☐
Bronchitis, asthma or other chest condition?	☐	☐
Fainting attacks, giddiness, blackouts, epilepsy?	☐	☐
Muscle problems (e.g. myopathy, dystrophy, paralysis)?	☐	☐
Heart problems (e.g. angina, blood pressure problems or stroke)?	☐	☐
Diabetes (or does anyone in your family)?	☐	☐
Neurological (nerve) diseases (e.g. 'neuropathies', MS etc.)?	☐	☐
Arthritis?	☐	☐
Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐	☐
Any infectious diseases (including HIV, hepatitis, TB)?	☐	☐
Stomach ulcers/hiatus hernia/indigestion?	☐	☐

Details:

Did you, as a child or since, have	Yes	No
Rheumatic fever, heart murmur or chorea?	☐	☐
Liver disease (e.g. jaundice, hepatitis)?	☐	☐

	Yes	No
Kidney disease?		
Any other serious illness?		

Details:

Did you, as a child or since, have	Yes	No
Blood refused by the Blood Transfusion Service?		
A bad reaction to general or local anaesthetic?		
A joint replacement or other implant?		
Treatment that required you to be in hospital?		
Heart surgery?		
Brain surgery?		
Growth hormone treatment before the mid 1980s?		
A close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease (CJD)?		
Steroid treatment?		

Details:

How many units of alcohol do you drink per week?

Units per week (A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitif)

Smoking and Chewing	Yes	No	In the past
Do you smoke any tobacco products now (or did you in the past)? Times per day			
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)? Times per day			

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

Completed by (please tick)

Self Parent Guardian Dentist

Signature: .... Date: ....

Dentist signature: .... Date: ....

Date: ....

List of any changes: ....

....

Alcohol units p/w: Smoking time p/d: Patient Initials: Dentist Initials:

Date: ....

List of any changes: ....

....

Alcohol units p/w: Smoking time p/d: Patient Initials: Dentist Initials:

Date: ....

List of any changes: ....

....

Alcohol units p/w: Smoking time p/d: Patient Initials: Dentist Initials: