

Reviewed by dentist

Date:

Dentists initials:



Confidential Medical History Form

We ask you for information about your general health to help us treat you safely.

Please fill in your contact details below, answer the health questions and **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.

Reviewed by dentist:

Surname: First name/s: Title:

Male Female

NHS number (10 digit number) *e.g. 1234 5678 11*

Date of birth:

Address:

.....

.....

Postcode:

Telephone number home: Mobile:

Email:

Occupation:

In the event of an emergency, please contact:

.....

Doctor's name and address:

.....

Doctor's telephone number:

Are you currently:

	Yes	No	Please give details
Receiving treatment from a doctor, hospital or clinic?	<input type="checkbox"/>	<input type="checkbox"/>
Taking any prescribed medicines (e.g. tablets, ointments injections or inhalers, including contraceptives and hormone replacement therapy or bisphosphonates)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had steroid therapy in the last two years?	<input type="checkbox"/>	<input type="checkbox"/>
Carrying a medical warning card?	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant or possibly pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

P.T.O



Have you ever had or do you have:

	Yes	No	Please give details
Heart problems, angina, blood pressure problems, heart surgery, pacemaker or stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis, asthma or any other chest condition?	<input type="checkbox"/>	<input type="checkbox"/>
Bruising or persistent bleeding following injury, tooth extraction or surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Any infectious diseases (including HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease (e.g. jaundice, hepatitis) or kidney disease? Or any other serious illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (or does anyone in your family)?	<input type="checkbox"/>	<input type="checkbox"/>
Fainting attacks, giddiness, blackouts, epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to medicines (e.g. penicillin), substances (e.g. latex) or foods?	<input type="checkbox"/>	<input type="checkbox"/>
A bad reaction to general or local anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>
Bone or joint disease?	<input type="checkbox"/>	<input type="checkbox"/>
Treatment that required you to be in hospital?	<input type="checkbox"/>	<input type="checkbox"/>

This section is relevant to adults

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/aperitif.) units per week

Do you smoke or chew tobacco, pan, use gutkha or supari now (or did you in the past)?

Yes	No	In the past	<input type="text"/> per day
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If there is any other information your dentist needs to know, please write below and discuss this with them at your appointment.

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.....
.....

Patient signature: **Date:**