CONFIDENTIAL MEDICAL HISTORY FORM

To obtain the safest and best treatment your dentist needs to know of any problems which may affect your treatment. All information will be kept strictly confidential.

Title (Mr/Mrs/Miss etc.)	First Name	Family Name
Date of Birth	Occupation	Email
Address		
Telephone Home	Work	Mobile
Pregnant/Possibly Pregnant? Yes / No	How long since you last received dental treatment?	
How did you hear about us and/or whom may we thank for referring you?		
Your Doctor's name and address		

Are you currently:	**Yes**	**No**	**Details**
Attending or receiving treatment from a doctor, clinic, hospital or specialist?			
Taking any medicines (tablets, creams, ointments, injections or inhalers, in-			
Carrying a medical warning card?			
Have you ever suffered from:			
Allergies to any medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods?			
Bronchitis, asthma or other chest condition?			
Fainting attacks, giddiness, blackouts or epilepsy?			
Heart problems, angina, blood pressure problems or stroke?			
Diabetes (or does anyone in your family)?			
Bone or Joint Disease?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Liver Disease (e.g. jaundice, hepatitis) or kidney disease?			
Any other serious illness, HIV, Hep B/C or other infectious disease?			
Having your blood refused by the Blood Transfusion Service?			
Had any blood tests and inoculations?			
A bad reaction to general or local anaesthetic?			
Being hospitalised? If "Yes" for what and when?			
Heart surgery?			
Do you:			**Times Per Day**
Smoke or chew any tobacco products now or in the past?			

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.

Are there any aspects concerning your health that you think the dentist should know about such as self-prescribed medicines (e.g. aspirin) or any disabilities you may have?

Signature _____Self/Guardian Date_____