Confidential Medical History Form

We ask you for information about your general health to help us treat you safely. Please write your contact details below, answer the health questions and 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 by the people caring for you.

Completed by (please tick) self ☐ parent ☐ guardian ☐

Patient signature _____ Date _____

Dentist signature _____ Date _____

Medical history update

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

Date	Any changes?	List changes below	Patient initials

Title: **Last name:**

First name:

Date of birth: ____/____/____ **Sex:** Male Female

Child Patients **School attended:**

Address:

Postcode:

Telephone number (home):

Mobile number:

Email:

Occupation:

In the event of an emergency, please contact

Name:

Telephone number: **Relationship to you:**

Doctor's details

Doctor's name: **Telephone number:**

Address:

Postcode:

Are you currently	yes / no	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 or possibly pregnant?		

Have you ever suffered from	yes / no	give details
Allergies to medicines (eg penicillin), substances (eg latex/rubber) or foods?		
Bronchitis, asthma or other chest condition?		
Fainting attacks, giddiness, blackouts, 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 (eg jaundice, hepatitis) or kidney disease?		
Any other serious illness or infectious disease?		

Have you ever suffered from	yes / no	give details
Blood refused by the Blood Transfusion Service?		
A bad reaction to general or local anaesthetic?		
Treatment that required you to be in hospital?		
Heart surgery?		

Alcohol

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

Smoking	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 (eg aspirin) or any disabilities you may have.