

# CONFIDENTIAL MEDICAL HISTORY

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

**SURNAME** Mr / Mrs / Miss / Ms \_\_\_\_\_ **SEX : MALE / FEMALE**

**FORENAME (S)** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**POSTCODE** \_\_\_\_\_

**TEL: Home** \_\_\_\_\_ **Work** \_\_\_\_\_ **Mobile** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_ **OCCUPATION** \_\_\_\_\_

**WHEN DID YOU LAST RECEIVE DENTAL TREATMENT** \_\_\_\_\_

**YOUR DOCTOR'S NAME & ADDRESS** \_\_\_\_\_

**YOUR E-MAIL** \_\_\_\_\_

	Yes	No	
Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Are you taking any medicines, tablets, drugs or injections or using any creams, ointments or inhalers?			
Are you taking or have you taken steroids in the last 2 years?			
Are you allergic to penicillin?			
Are you allergic to any medicines, foods or materials?			
Do you carry a warning card?			
Are you pregnant or a nursing mother?			
Are you HIV positive?			
Have you had rheumatic fever?			
Have you had jaundice, liver or kidney disease or hepatitis?			
Have you ever had a Stroke?			
Did you as a child or since have brain surgery, growth hormone treatment before the mid 1980's or have a close relative with Creutzfeldt Jakob Disease?			

	Yes	No	
Have you ever been told you have a heart murmur, heart problem, angina or high blood pressure?			
Have you ever had your blood refused by the Blood Transfusion Service?			
Have you ever had a bad reaction to a local or general anaesthetic?			
Have you had a joint replacement or other implant?			
Have you been hospitalised for any reason?			
Do you have arthritis?			
Do you have a pacemaker or have you had heart surgery?			
Do you suffer from hay fever, eczema, or any other allergy?			
Do you suffer from bronchitis, asthma or other chest condition?			
Do you have fainting attacks, giddiness, blackouts or epilepsy?			
Do you have diabetes or does anyone in your family?			
Do you bruise easily or suffer persistent bleeding following a tooth extraction or injury or does anyone in your family?			
Any other health condition?			
On average, how much of the following do you consume per day?	Cigarettes _____ Alcoholic Drinks _____		

**How did you hear about us**  
**Are you anxious about dental treatment**  
**Have you got private dental insurance**

**SIGNED :** \_\_\_\_\_

**DATE :** \_\_\_\_\_