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 inside 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.

Surname _____

First Name/s _____ **Title** _____

Sex Male ☐ Female ☐

Date of Birth day ____ month ____ year ____

Address _____

_____

_____

_____ **Postcode** _____

Telephone home _____

mobile _____

In the event of an emergency, please contact: Name _____

Number _____

Email _____

Occupation _____

Doctor's name and address _____

_____

_____

_____

_____

Doctor's telephone _____

BDA

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?			
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 of 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

Tobacco use

	yes	no	in 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

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

Patient's signature _____ Date _____

Dentist's 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	No change	List any changes below	Patient's initials

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