DENTAL PRACTICE ON THE green

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.

Name:	Address:____
Date of Birth:	____ Postcode:
Title:- (circle as appropriate) Mr/Mrs/Miss/Ms/Master/Dr/Prof	Tel (home):
Occupation:	Mobile:
Date last received dental treatment:	Tel (work)
Your doctor's name & address: _________________ ____	Email:

Are you currently:	Y	N	Give details:
Receiving treatment from a doctor, hospital or clinic?			
Take any regular / prescribed medication?			
Pregnant / possible pregnant?			
Carrying a medical warning card?			
Have you ever suffered from:	**Y**	**N**	**Give details:**
Allergies to any medication / substances (e.g. antibiotics or latex) or food?			
Diabetes?			
Hay Fever or Eczema?			
Fainting attacks, giddiness, blackouts or Epilepsy?			
Bronchitis, Asthma or other chest condition?			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases including HIV or Hepatitis?			
Heart problems, angina, blood pressure problems, stroke or pacemaker?			
A bad reaction to general or local anaesthetic?			

Rheumatic Fever or Chorea (St Vitus Dance)?			
Liver disease (e.g Jaundice, Hepatitis) or kidney disease?			
Any other serious illness or infectious disease?			
Blood refused by the Blood Transfusion Service?			
A joint replacement or implant?			
Treatment that required you to be in hospital?			
Heart surgery?			
Brain surgery?			
Smoking:	**Y**	**N**	**In past? How many?**
Do you smoke or chew tobacco, Pan, Supari or Gutka			
Alcohol:			
How many units of alcohol do you drink per week?			

Completed by: Self / Parent / Guardian (Please circle)

Signature:_________________________ Date:___________________

Medical History Update: Have there been any changes in your health, medicines, injections or tablets since your last course of treatment?

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Date:		Date:		Date:		Date:		Date:		Date:	
Sign.		Sign.		Sign.		Sign.		Sign.		Sign.	