Confidential medical history form

Like all dentists, we ask patients for information about their general health to help us treat them safely. Please write your contact details below, answer the health questions inside and then sign the form on the back page. We will show you the form at later visits so that you can tell us whether there has been any change in your general health. All information will be kept strictly confidential by the people caring for you.

Personal details

First name(s):

Surname: Title:

Sex: Male ☐ Female ☐ Date of birth:

Address:

Postcode:

Telephone: Home:

Work:

Mobile:

E-mail:

Occupation:

Doctor's details

Doctor's name & address:

Postcode:

Doctor's telephone:

Medical history form

Are you currently

	Yes	No	Give details
Pregnant?	☐	☐	
Receiving treatment from a doctor, hospital or clinic?	☐	☐	
Taking any prescribed medicines (eg tablets, ointments, injections or inhalers including Bisphosphonates, contraceptives and hormone replacement therapy)?	☐	☐	

Do you suffer from

	Yes	No	Give details
Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?	☐	☐	
Hay fever or eczema?	☐	☐	
Bronchitis, asthma or chest complaint?	☐	☐	
Fainting attacks, blackouts or Epilepsy?	☐	☐	
Heart problems, angina, blood pressure problems or stroke?	☐	☐	
Diabetes (or any family history)?	☐	☐	
Osteoporosis?	☐	☐	
Bruising or prolonged bleeding after injury, tooth extraction or surgery?	☐	☐	
Any infectious diseases (including HIV and hepatitis)?	☐	☐	

Have you ever had

	Yes	No	Give details
Rheumatic Fever or chorea?	☐	☐	
Liver disease (eg jaundice or hepatitis) or kidney disease?	☐	☐	
Any other serious illness?	☐	☐	
Blood refused by the Blood Transfusion Service?	☐	☐	
A bad reaction to general or local anaesthetic?	☐	☐	
A Joint replacement or other implant?	☐	☐	
Treatment that required you to be in hospital?	☐	☐	
Heart surgery?	☐	☐	
Brain surgery?	☐	☐	
Growth hormone treatment (eg tablets, ointments, injections) before the mid 1980s?	☐	☐	
A close relative with Creutzfeldt Jakob Disease?	☐	☐	

Drinking

How many units of alcohol do you drink per week? units/week

(A unit is half a pint of lager, a single measure of spirits or a single glass of wine)

Smoking and Chewing

	Yes	No	Past	Times per day
Do you smoke any tobacco products now (or in the past)?	☐	☐	☐	
Do you chew tobacco, pan, use gutkha or supari now (or in the past)?	☐	☐	☐	

Please give any other details which your dentist might need to know about, such as self-prescribed medicines (e.g. asprin)

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Completed by *(please tick)*: Self ☐ Parent ☐ Guardian ☐

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 of changes	Patient's intials

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