



# MEDICAL HISTORY FORM CONFIDENTIAL

To ensure the best and safest care, your dentist needs to know of any medical conditions which may affect your treatment.

<b>TITLE:</b>		<b>FIRST NAME(S):</b>		<b>SURNAME:</b>	
<b>DATE OF BIRTH:</b>		<b>GENDER: MALE</b>	<b>FEMALE</b>	<b>OCCUPATION:</b>	
<b>HOME ADDRESS:</b>				<b>POST CODE:</b>	
<b>TEL NO: HOME</b>		<b>WORK</b>		<b>MOBILE</b>	
<b>Email add:</b>					
<b>Next of kin details: (Name and contact number)</b>					
<b>DOCTOR'S NAME:</b>					
<b>ADDRESS:</b>			<b>PHONE NO:</b>		
<b>Are you?</b>		<b>YES</b>	<b>NO</b>	<b>DETAILS:</b>	
1. Attending or receiving treatment from a doctor, hospital, clinic or specialist? If so for what?					
2. Taking any medicines from your doctor? Please list over the page.				(include all tablets, ointments, injections, contraceptive pill.)	
3. Taking any self prescribed drugs?					
4. Allergic to any medicines or materials, such as latex?					
5. Pregnant or trying to conceive?					
Please circle the response that applies to you.					
<b>Do you smoke?</b>		Never	Used to smoke	1-10 a day	More than 10 a day
<b>Do you consume alcohol?</b>		Never	Rarely	Weekly	Daily
<b>Have you?</b>		<b>YES</b>	<b>NO</b>	<b>DETAILS:</b>	
1. Had a serious illness or operation in the last 5 years?					
2. Taken steroids in the last 2 years?					
3. Had Bisphosphonate therapy? If so, for how long?					
4. Had a malignant disease, chemo or radiotherapy or bone marrow transplant?					
5. Had jaundice, liver disease or hepatitis?					
6. Had any recent blood tests or inoculations?					
7. Had a bad reaction to local anaesthetic?					
8. Ever been told you have a heart problem. Such as a murmur, angina, high blood pressure, heart attack, infective endocarditis?					
9. Suffered from/are you suffering from an infectious disease?					
10. Ever had a stroke?					
<b>Do you?</b>		<b>YES</b>	<b>NO</b>	<b>DETAILS:</b>	
1. Have problems lying flat?					
2. Experience chest pain, on exertion or at rest?					
3. Have heart palpitations without exertion?					
4. Have a pacemaker?					
5. Bruise easily or have a tendency to bleed after injury or surgery?					
6. Do you have fainting attacks, giddiness, blackouts or epilepsy?					
7. Carry a warning card/ medical alert band?					
8. Suffer from bronchitis, asthma or other lung problems?					
9. Have diabetes?					
10. Have thyroid disease?					
11. Have kidney disease?					
12. Have arthritis?					
13. Have any neurological problems? Such as Multiple sclerosis, Parkinson's Disease or other.					
14. Suffer from anxiety when attending dental appointments?				If yes, please score; 1-5 (1 being low, 5 being high)	
Do you have any other health problems that you think the dentist should know about?					



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**Communication consent:**

We process personal data for the purposes of providing optimum dental healthcare, sending important updates to you, providing you with news about what is happening at the Practice and informing you about our services, such as treatments available. You can withdraw your consent at any time.

The Practice can contact me about my treatment:				By email:		By text:		
I would like to receive important Practice announcements and updates.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	By email:		By post:	
I would like to receive details of new treatments and services at the Practice.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	By email:		By post:	

Your personal information is never passed to third parties for their own marketing. We have strict arrangements with companies who process your data on our behalf.

For further details about how we process your personal information and your data rights please see our Privacy Notice, available in our waiting room, on our website [www.stpaulsdentalpractice.co.uk](http://www.stpaulsdentalpractice.co.uk) or contact us via 01626 365896 or [info@stpaulsdentalpractice.co.uk](mailto:info@stpaulsdentalpractice.co.uk)

**Please detail in this section, ANY drugs you are currently taking.**

Drug	Dose	Frequency taken

<b>Completed by:</b>	<b>Signature:</b>	<b>Date:</b>
If you are signing on behalf of someone, please state your relationship (Parent/Guardian/Carer):		

<b>Have there been any changes in your health/ medicines since you last attended?</b>			
<b>Details:</b>		<b>Signed:</b>	<b>Date:</b>
		<b>Signed:</b>	<b>Date:</b>
		<b>Signed:</b>	<b>Date:</b>
		<b>Signed:</b>	<b>Date:</b>
		<b>Signed:</b>	<b>Date:</b>
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