



# 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?  |  |                       |                  |   |                    |

