CONFIDENTIAL MEDICAL HISTORY FORM

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

TITLE:	FIRST NAME(S):				SURNAME:
DATE OF BIRTH:	GENDER: MALE		FEMALE		OCCUPATION:
HOME ADDRESS: POST CODE:					
TEL NO: HOME	WORK				MOBILE
Email:					
DOCTOR'S NAME: ADDRESS:					PHONE NO:

Are you?	YES	NO	DETAILS:
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.

Do you smoke?	Never	Used to smoke	1-10 a day	More than 10 a day
Do you consume alcohol?	Never	Rarely	Weekly	Daily

Have you?	YES	NO	DETAILS:
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?			

Do you?	YES	NO	DETAILS:
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.			
Do you have any other health problems that you think the dentist should know about?			

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

Drug	Dose	Frequency taken

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

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