CONFIDENTIAL MEDICAL HISTORY FORM

Title ……
Surname …….
First names ……..
Sex M/F ……..
Date of Birth ……
Ethnicity……..
Address……
……
Postcode……..

Telephone
Mobile ……
Home ……
Work ……..

Email ……
Occupation ……..

In the event of an emergency (next of kin)
Name ……
Telephone number ……..
Doctors name ……
Surgery name ……..

Are you currently:
Receiving treatment from a doctor, hospital or clinic?
……
Taking any prescribed medicines
(eg. tablet, injections or inhalers)?
……

Carrying a medical warning card? ……

Pregnant or possibly pregnant? ……

Have you ever suffered from:
Allergies to medicines or any substances
(eg. Penicillin / Latex / foods)? ……

Bronchitis, asthma, or any other chest condition?

……

Fainting attacks, giddiness, blackouts or epilepsy?

……

Heart problems, angina, blood pressure problems, or stroke? ……

Diabetes? ……

Bone or joint disease? ……

Bruising or persistent bleeding following injury, Tooth extraction or surgery? ……

Liver disease (eg, jaundice, hepatitis) or Kidney disease? ……

Any other serious illness or infectious disease?……
Hep B or Hep C ……
Blood refused by the Blood Transfusion Service? ……

A bad reaction to general or local anaesthetic? ……

Treatment that required you to be in hospital? ……

Heart surgery? ……

Alcohol
How many units of alcohol do you drink per week?
(A unit is half a pint of lager, a single measure of spirits or a single small glass of wine)
Units per week ……

Smoke / E-cigarette (please tick)
Yes …… **No** ……

Please give any other details which your dentist may need to know about medicines you're taking or Such as self-prescribed medicines. (eg, aspirin) or any disabilities.

……
……
……
……

Completed by ……..

Patient Signature …… Date ……