# *the* Paddington Dental *practice*

## CONFIDENTIAL MEDICAL HISTORY FORM

We ask you for information about your general health to help us treat you safely. Please write your contact details below, answer the health questions and then sign the form on the back page. We will use this form at later visits to discuss any changes in your general health. All information will be kept strictly confidential by the people caring for you.

| | |
|---|---|
| Title | |
| Last Name | |
| First Name | |
| Date of birth | |
| Address | |
| Phone Number : Home | |
| Phone Number: Work | |
| Phone Number: Mobile | |
| Email Address | |
| Occupation | |

In the event of emergency, please contact:

| | |
|---|---|
| Name | |
| Phone Number | |
| Relationship to you | |

GP details:

| | |
|---|---|
| Doctor's Name | |
| Address | |
| Phone Number | |

| Are there any concerns that you may have about your teeth? |
| --- |
| |

| Is there anything you would like to improve about your smile? |
| --- |
| |

| We now offer dermal fillers and wrinkle reduction with Botulinum Type A. | | |
| --- | --- | --- |
| Would you be interested in this service? | Yes | No |

| Are you currently: | Yes | No | Give Details |
| --- | --- | --- | --- |
| Receiving treatment from doctor/ hospital/clinic? | | | |
| Taking any prescribed medicine (tablets, injections, inhalers – including contraceptives and HRT)? | | | |
| Pregnant or possibly pregnant? | | | |

| Have you ever had: | Yes | No | Give Details |
| --- | --- | --- | --- |
| Allergies to medicines, materials or foods? (eg. penicillin, latex etc) | | | |
| Bronchitis, asthma or other chest conditions? | | | |
| Fainting attacks, giddiness, epilepsy, blackouts? | | | |
| Heart problems, angina, blood pressure or stroke? | | | |
| Diabetes (or does anyone in the family)? | | | |
| 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? | | | |
| 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? | | | |

## Alochol

| How many units of alcohol do you drink per week? | units |
|---|---|

1 unit = half a pint of lager, a single measure of spirit or a small glass of wine)

## Smoking

| | **Yes** | **No** | **How many times a day?** |
|---|---|---|---|
| Do smoke any tobacco products now (or did you in the past)? | | | |
| Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)? | | | |

## Other details:

Please give any other details which your dentist might need to know about, such as self-prescribed medicines (eg. aspirin) or any disabilities you may have.

| |
|---|
| |

| **Completed by** (Please tick) | Self | Parent | Guardian |
|---|---|---|---|

| **Signature** | |
|---|---|
| **Date** | |

| **Dentist Signature** | |
|---|---|
| **Date** | |

# Medical History Update (for future appointments)

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary and note any changes below.

| Date | Any changes? | | List Changes | Patient Signature |
|---|---|---|---|---|
| | Yes | No | | |
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