

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	
Sex: Male/Female	
Address	
Phone numbers (home/work/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 derma fillers and wrinkle reduction with Botulinum Type A. Would you be interested in this service?

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?

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?			

Alcohol

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

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.

