

Confidential Medical History

To provide the best and safest treatment, your dentist needs to know of any problems which may affect your treatment

Name: _____ DOB: ____/____/____ Sex: Male / Female

Address: _____ Post Code: _____ Mobile no: _____

Home tel. no: _____ E-Mail: _____ Occupation: _____ NHS Number: _____

GP's Name and Address: _____ Next of Kin: _____ Tel: _____

	Yes	No	Details
Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Are you taking any medicines from your doctor? (tablets, creams, injections, other)			
Are you pregnant or a nursing mother?			
Are you taking or taken steroids in the last two years?			
Are you allergic to any medicines, foods or materials?			
Have you had Rheumatic fever or Chorea?			
Have you had jaundice, liver, kidney disease or hepatitis?			
Have you ever been told you have a heart murmur or heart problem?			
Have you had angina, blood pressure or a heart attack?			
Have you had any infectious diseases (including Hepatitis & HIV)?			
Have you had a bad reaction to a general or local anaesthetic?			
Have you been hospitalised? If YES what for and when?			
Do you have a joint replacement or other implants?			
Do you have a pacemaker, or have you had any form of heart surgery?			
Do you suffer from hay fever, eczema or any other allergy?			
Do you suffer from bronchitis, asthma or any other chest condition?			
Do you have fainting attacks, giddiness, blackouts or epilepsy?			
Do you or any member of your family suffer from diabetes?			
Do you suffer from glaucoma or any other illness of the eyes?			
Do you bruise easily or following a tooth extraction, surgery or injury have you or your family bled so as to cause you to be worried?			
Do you carry a medical warning card?			
Do you ever get cold sores?			
How many units of alcohol do you drink per week?			
Do you smoke any tobacco products now (did you in the past?) If yes, how many per day?			
Are there any other aspects concerning your health that you think the dentist should know about?			

I understand that my dentist may discontinue treatment if I fail to fully disclose all medical information, if I fail to attend appointment(s) or fail to give at least 24 hours cancellation notice. I understand that my dentist does not have to treat me if my behaviour is aggressive or abusive or if there is an irrevocable breakdown in the professional relationship.

The above information is for the use of NHS Dentist alone and is held in accordance with the data protection act 1998.

Completed by: Self/ Patient / Guardian:

Date: _____ Signature: _____ Dentist's signature _____

Have there been any changes in your health, medicines, injections or tablets since your last course or treatment? Yes / No

Date _____ Patient signature _____ Dentist signature _____

Have there been any changes in your health, medicines, injections or tablets since your last course or treatment? Yes / No

Date _____ Patient signature _____ Dentist signature _____