**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 inside then sign the form on the back page. We will use this form at later visits to discuss any change in your general health. All information will be kept strictly confidential by the people caring for you.

### Surname First Name/s Title

**Sex** Male Female

**Date of Birth** day month year

### Address

 **Postcode**

**Telephone** home mobile

### In the event of an emergency, please contact:

Name Number

### Email Occupation Doctor’s name and address

**Doctor’s telephone**

 **Are you currently yes no Give details**

Receiving treatment from a

Doctor, hospital or clinic?

Taking any prescribed

Medicines (eg tablets,

Ointments, injections or

Inhalers, including contraceptives

And hormone replacement therapy)?

Carrying a medical

Warning card?

Pregnant or possibly pregnant?

#  Have you ever suffered from yes no Give details

Allergies to medicines

(eg penicillin), substances

(eg latex/rubber) or foods?

Bronchitis, asthma or other

Chest condition?

Fainting attacks, giddiness,

Blackouts, epilepsy?

Heart problems, angina, and blood

Pressure problems, or stroke?

Diabetes (or does anyone in

Your 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 of units of alcohol do you drink per week? (A unit is half a pint of lager, a single measure of spirits

or a single glass of wine/aperitif.) Units per week

#  Tobacco use yes no in past

Do you smoke any tobacco products?

Now (or did you in the past)? Times per day

Do you chew tobacco, pan, and use gutkha

Or supari now (or did you in the past)? Times per day

**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**

Patient’s signature Date

Dentist’s signature Date

Guardian

Parent

Self

**Completed by (please tick)**

#  Medical history update

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

Date No change List any changes below Patient’s initials