Confidential Medical History Form

NAME:	D.O.B:
TELEPHONE NUMBER:	ADDRESS:
OCCUPATION:	
DOCTORS NAME & ADDRESS	POST CODE:

	YES	NO	PLEASE GIVE DETAILS
Are you currently awaiting, attending or receiving treatment from a doctor or health care professional?	☐	☐	
Taking any prescribed medicines	☐	☐	
Carrying a medical warning card?	☐	☐	
IF FEMALE – Are you pregnant?	☐	☐	If yes, when is your baby expected?
Allergies to any medicines, substances or food?	☐	☐	
Hay fever or eczema?	☐	☐	
Bronchitis, asthma, or other chest condition?	☐	☐	
Fainting attacks, giddiness, blackouts, epilepsy?	☐	☐	
Heart problems / heart surgery, angina, blood pressure problems, or ever had a stroke?	☐	☐	
Diabetes (or does anybody in your family)?	☐	☐	If yes, what Type?
Arthritis?	☐	☐	
Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐	☐	
Liver disease or kidney disease?	☐	☐	
Blood refused by Blood Transfusion Service?	☐	☐	
Do you suffer Fainting or dizziness?	☐	☐	
Do you regularly drink alcohol, if so what is your average weekly consumption?	☐	☐	
Do you smoke tobacco or use nicotine products now (or in the past)?	☐	☐	If yes, how many per day or how often?
Treatment that required you to be in hospital?	☐	☐	
Do you chew tobacco, pan, use gutkha, or supari now (or in the past)?	☐	☐	
Please give any other details regarding your health that you dentist might need to know?	☐	☐	

How did you hear about the practice?

When was your last examination? When was your last X-rays?

If you could change your teeth what would you like to achieve?

How would you describe your experience of dentistry to date?

Signature:…… **Date:** DD / MM / YY