CONFIDENTIAL MEDICAL HISTORY

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

SURNAME Mr / Mrs / Miss / Ms _____ **SEX : MALE / FEMALE**

FORENAME (S) _____

ADDRESS _____

_____ **POSTCODE** _____

TEL: Home _____ **Work** _____ **Mobile** _____

DATE OF BIRTH _____ **OCCUPATION** _____

WHEN DID YOU LAST RECEIVE DENTAL TREATMENT _____

YOUR DOCTOR'S NAME & ADDRESS _____

YOUR E-MAIL _____

	Yes	No	
Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?	☐	☐	
Are you taking any medicines, tablets, drugs or injections or using any creams, ointments or inhalers?	☐	☐	
Are you taking or have you taken steroids in the last 2 years?	☐	☐	
Are you allergic to penicillin?	☐	☐	
Are you allergic to any medicines, foods or materials?	☐	☐	
Do you carry a warning card?	☐	☐	
Are you pregnant or a nursing mother?	☐	☐	
Are you HIV positive?	☐	☐	
Have you had rheumatic fever?	☐	☐	
Have you had jaundice, liver or kidney disease or hepatitis?	☐	☐	
Have you ever had a Stroke?	☐	☐	
Did you as a child or since have brain surgery, growth hormone treatment before the mid 1980's or have a close relative with Creutzfeldt Jakob Disease?	☐	☐	

	Yes	No	
Have you ever been told you have a heart murmur, heart problem, angina or high blood pressure?	☐	☐	
Have you ever had your blood refused by the Blood Transfusion Service?	☐	☐	
Have you ever had a bad reaction to a local or general anaesthetic?	☐	☐	
Have you had a joint replacement or other implant?	☐	☐	
Have you been hospitalised for any reason?	☐	☐	
Do you have arthritis?	☐	☐	
Do you have a pacemaker or have you had heart surgery?	☐	☐	
Do you suffer from hay fever, eczema, or any other allergy?	☐	☐	
Do you suffer from bronchitis, asthma or other chest condition?	☐	☐	
Do you have fainting attacks, giddiness, blackouts or epilepsy?	☐	☐	
Do you have diabetes or does anyone in your family?	☐	☐	
Do you bruise easily or suffer persistent bleeding following a tooth extraction or injury or does anyone in your family?	☐	☐	
Any other health condition?	☐	☐	
On average, how much of the following do you consume per day?	Cigarettes_____	Alcoholic Drinks_____	

How did you hear about us
Are you anxious about dental treatment
Have you got private dental insurance

SIGNED :_____ **DATE :** _____

Whitehouse files : Confidential Medical History

Send Via Email