

CONFIDENTIAL MEDICAL HISTORY

Ref: _____

To help us treat you safely it is important that we ask you the following questions about your general health. Please tick any of the boxes that apply, and if necessary add any additional details. All information provided will be kept strictly confidential.

First Name _____ **Surname** _____ **Date of Birth** _____

- HIV Positive
- Diabetes
- Arthritis
- Rheumatic Fever or Chorea
- Chronic bronchitis, Asthma, or any other Respiratory Disease
- Epilepsy, blackouts, giddiness or fainting
- Hepatitis, Jaundice, Liver or Kidney Disease
- Excessive bleeding and/or Bleeding Disorders
- High blood pressure or Angina
- Heart Disease, Heart Attack or any related complaint
- Heart surgery or Pacemaker
- Steroid therapy in last two years
- Herpes, cold sores
- Undergone blood tests
- Refused blood donation
- Any allergies
- Allergic reaction to Local or General Anaesthetic
- Mother of a child under 12 months
- Expecting a baby
- Joint replacement operation
- Undergoing any Medical Treatment
- Taking any medication
- Undergone hospitalisation that may affect dental care
- Any other serious illness or related medical condition

We are now able to send out recall appointments by email and text message. Please provide your details below so we can contact you this way.

Email: _____

Mobile: _____

Doctors Name and Address

Medication and further details:

Signed _____

Date _____