

# CONFIDENTIAL MEDICAL HISTORY

To help us treat you safely it is important that we ask you the following questions about your general health. Please answer all questions by ticking 'yes' or 'no' and if necessary add any additional details. All information provided will be kept strictly confidential.

<b><i>Surname</i></b>		<b><i>First name(s)</i></b>	
<b><i>Title</i></b>	<b><i>Date of Birth</i></b>		<b><i>Sex</i></b>
<b><i>Address</i></b>			
<b><i>Postcode</i></b>	<b><i>Home phone</i></b>	<b><i>Work phone</i></b>	
<b><i>Occupation</i></b>			
<b><i>Doctors name &amp; address</i></b>			
<b><i>Are you?</i></b>	<b><i>No</i></b>	<b><i>Yes</i></b>	<b><i>Details</i></b>
Under treatment from your doctor, a hospital or clinic.			
Taking any medication (tablets, pills, medicines, inhalers, creams, ointments, injections).			
Allergic to anything (antibiotics eg penicillin, pollen, latex or any other substance).			
Pregnant.			
<b><i>Have you ever had?</i></b>	<b><i>No</i></b>	<b><i>Yes</i></b>	<b><i>Details</i></b>
Rheumatic fever or chorea.			
Any heart problems (angina, heart attack, stroke, heart murmur, heart surgery, high or low blood pressure).			
Any chest problems (bronchitis, asthma, tuberculosis).			
Hepatitis, jaundice, liver or kidney disease.			
Epilepsy, fainting or giddiness.			
Hay fever or eczema.			
A joint replacement or other implant.			
Blood refused by the blood transfusion service.			
Growth hormone treatment before the mid 1980s.			
			Please continue overleaf

<i>Have you ever had</i>	<i>No</i>	<i>Yes</i>	<i>Details</i>	
A bad reaction to local or general anaesthetic.				
Anaemia or other blood diseases.				
Any other serious illness.				
<i>Do you?</i>	<i>No</i>	<i>Yes</i>	<i>Details</i>	
Have diabetes (or does anyone in your family).				
Have CJD (or does anyone in your family).				
Have any infectious disease (including HIV and hepatitis).				
Have a heart pacemaker.				
Have arthritis.				
Ever have cold sores				
Bruise easily or bleed excessively following an injury, tooth extraction, or surgery.				
Carry a medical warning card.				
Have any other medical problems we should know about.				
<i>Do you?</i>	<i>No</i>	<i>Yes</i>	<i>In past</i>	<i>How many per day</i>
Smoke any tobacco products				
Chew tobacco products				
How many units of alcohol do you drink per week? (A unit is half a pint of beer, a single measure of spirits, or a glass of wine)				

***Name of person signing (if Parent/Guardian)***

<i>Patient signature</i>	<i>Date</i>
<i>Dentist signature</i>	<i>Date</i>

***Medical History Update***

<i>Date</i>	<i>Changes</i>	<i>Signature</i>