

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 on both pages and then sign the form on the back page. You must inform your dentist of any medical changes at each visit. All information will be kept strictly confidential by the people providing your care.

Title :	Surname :	Forename (s) :
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Address :

Postcode :	DOB :	Sex (M/F) :
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Telephone number (home) :	NI Number :
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Telephone Number (work) :	Ethnicity :
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Mobile Number :	Occupation :
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Email :

School Attended (child patients only) :

GP Name :	Telephone :
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GP's Address :

Emergency Contact Name :	Telephone :
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Relationship to you :

Are you currently:-	Yes / No	Please give details
Receiving any treatment from a doctor, hospital, clinic or specialist?	<input type="checkbox"/> <input type="checkbox"/>	

Taking any prescribed medicines (eg tablets, ointments, injections or inhalers, including contraceptives, steroids and hormone replacement therapy)?	<input type="checkbox"/> <input type="checkbox"/>	
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Carrying a medical warning card?	<input type="checkbox"/> <input type="checkbox"/>	
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Pregnant or possibly pregnant?	<input type="checkbox"/> <input type="checkbox"/>	
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Have you ever had or do you suffer from:-	Yes / No	Please give details
Allergies to medicines (eg penicillin), substances (eg latex/rubber) or foods?	<input type="checkbox"/> <input type="checkbox"/>	

Hayfever or eczema?	<input type="checkbox"/> <input type="checkbox"/>	Please State :
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Bronchitis, asthma or other chest condition?	<input type="checkbox"/> <input type="checkbox"/>	
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Please turn over the page and complete the questions on page two, then sign the form and hand it to your treating Dentist in surgery.

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Have you ever had or do you suffer from:-	Yes / No	Please give details
Any form of surgery (eg heart surgery)?	<input type="checkbox"/> <input type="checkbox"/>	Please State :
Heart problems, angina, thrombosis, rheumatic fever, blood pressure problems, or stroke?	<input type="checkbox"/> <input type="checkbox"/>	Please State :
Bruising or persistent bleeding following injury, tooth extraction or surgery?	<input type="checkbox"/> <input type="checkbox"/>	
A pacemaker?	<input type="checkbox"/> <input type="checkbox"/>	
Your blood refused by the Blood Transfusion Service?	<input type="checkbox"/> <input type="checkbox"/>	
A blood disorder (eg anaemia)?	<input type="checkbox"/> <input type="checkbox"/>	
Diabetes (or does anyone in your family)?	<input type="checkbox"/> <input type="checkbox"/>	Type 1 : <input type="checkbox"/> Type 2 : <input type="checkbox"/>
Liver disease (eg jaundice, hepatitis) or kidney disease?	<input type="checkbox"/> <input type="checkbox"/>	
Bone or joint disease (eg osteoporosis or arthritis)?	<input type="checkbox"/> <input type="checkbox"/>	
Epilepsy, fainting, giddiness or blackouts?	<input type="checkbox"/> <input type="checkbox"/>	Please State :
Any other serious illness (eg cancer) or infectious disease?	<input type="checkbox"/> <input type="checkbox"/>	
A bad reaction to general or local anaesthetic?	<input type="checkbox"/> <input type="checkbox"/>	
Treatment that required you to be admitted to hospital?	<input type="checkbox"/> <input type="checkbox"/>	
An artificial joint?	<input type="checkbox"/> <input type="checkbox"/>	
Coldsores?	<input type="checkbox"/> <input type="checkbox"/>	

Alcohol	Yes/No	How many units per week? (a unit is half a pint of lager, a single measure of spirits or a single glass of wine)	_____ Units
Do you drink alcohol?	<input type="checkbox"/> <input type="checkbox"/>		

Smoking	Yes	No	In the past	
Do you smoke any tobacco products now (or have you in the past)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ times per day
Do you chew tobacco, paan, use gutkha or supari now (or have you in the past)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ times per day

Please note any other details which your dentist might need to know, such as self prescribed medicines (e.g. aspirin) or any disabilities.

Completed by (please tick) : Self Parent Guardian

New Patients:
 Why have you chosen St George's Dental Practice for your care?

Patient Signature _____	Date _____
Dentist Signature _____	Date _____