Confidential Medical History Form

Welcome to our practice – We ask you for information about your general and dental health to help us treat you safely. Please write your contact details below, answer the health questions inside then sign the form on the back page. We will use this form at later visits to discuss any change in your general health. All information will be kept strictly confidential by the people caring for you.

Surname _____

First Name _____ Title _____

Sex Male ☐ Female ☐

Date of Birth day _____ month _____ year _____

Address _____

_____

_____ Postcode _____

Telephone home _____ mobile _____

work _____

email _____ NHS number _____

We may contact you through email with practice promotions. We will not share your email with any third parties. If you would like to opt out, please tick here ☐

Occupation _____

How did you find out about us (please be specific) _____

Doctor's name and address _____

_____

Doctor's telephone _____

Do you have any dental concerns, or are there treatments you are interested in?

_____

_____

_____

Next of kin, name, relationship and contact details

_____

_____

Do you have any preference for pain relief or anxiety control?

Please give details

_____

_____

When was your last dental visit? years _____ months _____

Completed by (please tick) self ☐ parent ☐ guardian ☐

Signature _____ Date _____

Medical history update

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

Date	No change	List any changes below	Patient's initials

Are you currently	yes	no	Please give details
Receiving treatment from a doctor, hospital or clinic?	☐	☐	
Taking any prescribed medicines (eg. tablets, ointments, injections or inhalers including contraceptives and hormone replacement therapy)?	☐	☐	
Carrying a medical warning card?	☐	☐	
Pregnant? (if yes give date of expectancy)	☐	☐	

Do you suffer from	yes	no	Please give details
Allergies to any medicines (eg. penicillin) substances (eg. latex / rubber or foods?)	☐	☐	
Hay fever or eczema?	☐	☐	
Bronchitis, asthma or other chest condition?	☐	☐	
Gastric problems, such as acid reflux?	☐	☐	
Fainting attacks, giddiness, blackouts, epilepsy?	☐	☐	
Heart problems, angina, blood pressure problems, or stroke?	☐	☐	
Diabetes (or does anyone in your family)?	☐	☐	
Arthritis?	☐	☐	
Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐	☐	
Any infectious diseases including (HIV and hepatitis)?	☐	☐	

Did you, as a child or since, have	yes	no	Please give details
Rheumatic fever or chorea?	☐	☐	
Liver disease (eg. jaundice, hepatitis) or kidney disease?	☐	☐	
Any other serious illness?	☐	☐	

Did you, as a child or since, have	yes	no	Please give details
Blood refused by the Blood Transfusion Service?	☐	☐	
A bad reaction to general or local anaesthetic?	☐	☐	
A joint replacement or other implant?	☐	☐	
Treatment that required you to be in hospital?	☐	☐	
Heart surgery?	☐	☐	

Please give any other details which your dentist might need to know about, such as self-prescribed medicines (eg. asprin)	yes	no	Please give details
	☐	☐	

Drinking

Do you drink alcohol, if so how many of units of alcohol do you drink per week?
(A unit is half a pint of lager, a single measure of spirits or a single glass of wine / aperitif.) ☐ ☐ _____ units per week

Smoking and chewing	yes	no	in past	
Do you smoke any tobacco products now (or did you in the past)?	☐	☐	☐	_____ times per day
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)?	☐	☐	☐	_____ times per day

Social history	yes	no	Please give details
Do you use recreational drugs?	☐	☐	
Have you now or in the past had any eating disorders (or unusual eating habits)?	☐	☐	