BOGNOR REGIS DENTAL

MEDICAL HISTORY FORM

TITLE: NAME:

DATE OF BIRTH: SEX:MALE/FEMALE

ADDRESS:

TEL NO: EMAIL:

HOW LONG SINCE LAST RECEIVED DENTAL TREATMENT:

YOUR DOCTOR'S NAME AND ADDRESS:

HOW DID YOU HEAR ABOUT US? :

EXPECTANT MOTHER: YES/NO

ARE YOU:	**YES**	**NO**	**DETAILS**
1.Attending or receiving treatment from a doctor, hospital, clinic or specialist?			
2.Taking any medicines from your doctor? (Tablets, creams, injections, other)			
3.Taking or have you taken steroids in the last two years?			
4.Allergic to any medicines, foods or materials?			
HAVE YOU: 1.Had rheumatic fever or been told you have a heart murmur?			
2.Had jaundice, liver, kidney disease or hepatitis?			
3.Ever had a heart attack or heart problem, infective endocarditis, heart valve replaced or any other form of heart surgery including pacemaker?			
4.Had any blood tests, inoculations etc?			
5.Ever had your blood refused by the Blood Transfusion Service?			
6.Had a bad reaction to a general or local anaesthetic?			
7.Ever been diagnosed or suspected as having V CJD or being HIV positive?			

8. Been hospitalised? If “YES” what for and when?			
DO YOU: 1.Have arthritis?			
2.Suffer from hay fever, eczema or any other allergy?			
3.Suffer from bronchitis, asthma or other chest conditions?			
4.Have fainting attacks, giddiness, blackouts or epilepsy?			
5.Have diabetes or does anyone in your family?			
6.Bruise easily. Following a tooth extraction, surgery or injury, have you or your family bled so as to cause you to be worried?			
7.Carry a warning card?			
8.Smoke and if yes how many a day?			
9.Drink alcohol and if yes how many units a week?			
Are there any other aspects concerning your health that you think the dentist should know about?			

PLEASE TELL US IMMEDIATELY IF YOUR MEDICAL HISTORY CHANGES! IT WILL HELP AVOID ANY PROBLEMS.

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Denplan
At the heart of dental care

Do you consent for us to contact you by Phone/ Text/Email/Letter? Yes / No

Are you happy for us to leave messages for you (answerphone/family member)? Yes / No

Are you happy for a family member to make or change appointments for you? Yes / No

If yes, please give name(s):

Are you happy for us to discuss any aspects of your dental treatment with a family member or partner? Yes / No

If yes, please give name(s):

Completed by: Self/Parent/Guardian.

Signature.....

Date……