Mains Drive Dental

FOR OFFICE USE

Surname | Initial(s)

Confidential Medical History Form

To obtain the best and safest dental care, your dentist needs to know of any health issues which may affect your treatment. This form will be used at later visits to discuss any change in your general health.
All information will be kept strictly confidential by the people who are caring for you.

PLEASE PRINT

NAME TITLE ..... FIRST NAME/S .....

SURNAME .....

ADDRESS

.....

.....

.....

POSTCODE

DATE OF BIRTH Day Month Year

OCCUPATION .....

TELEPHONE Home STD Code

Mobile

EMAIL

@

DOCTOR'S NAME ..... TELEPHONE NO

SURGERY / ADDRESS .....

EMERGENCY CONTACT ..... RELATIONSHIP .....

TELEPHONE NO

		Please ✓ yes	no	If **yes**, please give details
	Are you currently			
1	Attending or receiving treatment from a doctor/hospital/clinic?	☐	☐	
2	Taking any medicines prescribed or otherwise (eg tablets, ointments, injections or inhalers including contraceptives and hormone replacement therapy)?	☐	☐	
3	Pregnant or possibly pregnant?	☐	☐	
4	Carrying a medical warning card?	☐	☐	
	Have you ever suffered from			
5	Allergies to medicines (eg penicillin), substances (eg latex or rubber) or foods?	☐	☐	
6	Bronchitis, asthma or other chest condition?	☐	☐	
7	Fainting attacks, giddiness, blackouts, epilepsy?	☐	☐	
8	Heart surgery, other heart problems, angina, blood pressure problems or stroke?	☐	☐	
9	Diabetes (or does anyone in your family)?	☐	☐	
10	Bone or joint disease?	☐	☐	
11	Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐	☐	
12	Liver disease (eg jaundice, hepatitis) or kidney disease?	☐	☐	
13	Any other serious illness or infectious disease?	☐	☐	
14	Blood refused by the Blood Transfusion Service?	☐	☐	
15	A bad reaction to general or local anaesthetic?	☐	☐	
16	Treatment that required you to be in hospital? If 'yes' what for and when?	☐	☐	
	Alcohol			
17	How many units of alcohol do you drink per week? [A unit is half a pint of beer/lager/cider (3-4%ABV), a single measure of spirits (25ml 40%ABV) or a small glass of wine (50ml 13%ABV)]	……. units per week		
	Tobacco use	**yes**	**no**	**in past**
18	Do you smoke any tobacco products now (or did you in the past)?	☐	☐	☐ ……. times per day

19	Are there any other aspects concerning your health that you think we should know about?

Completed by (please **tick**) self ☐ parent ☐ guardian ☐ Year **202**

Patient signature …… Date ……..

Dentist signature ……..….. Date ……...