

Surname: _____ Title: _____

First name(s): _____

Sex: Male Female

Date of birth: _____ (day/month/year)

Address: _____

Postcode: _____

Telephone Home: _____ Work: _____

Occupation: _____

Doctors name and address: _____

Doctors Telephone: _____

Are you currently Yes No Give details

Pregnant? _____

Receiving treatment from a doctor, Hospital or clinic? _____

Taking any prescribed medicines (eg tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)? _____

Do you suffer from

Allergies to any medicines (eg penicillin), substances (eg latex/ rubber) or foods? _____

Hay fever or eczema? _____

Bronchitis, asthma or chest complaint? _____

Fainting attacks, blackouts or Epilepsy? _____

Heart problems, angina, blood pressure problems or stroke? _____

Diabetes (or any family history)? _____

Arthritis? _____

Do you suffer from (cont) Yes No Give details

Bruising or prolonged bleeding after injury, tooth extraction or surgery? _____

Any infections diseases (including HIV and hepatitis)? _____

Have you ever had

Rheumatic Fever or chorea? _____

Liver disease (eg jaundice or hepatitis) Or kidney disease? _____

Any other serious illness? _____

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? _____

Brain surgery? _____

Growth hormone treatment before the mid 1980s? _____

A close relative with Creutzfeldt Jakob Disease? _____

Drinking

How many 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) _____ units/week

Smoking and Chewing Yes No In past Times per day

Do you smoke any tobacco products now (or in the past)? _____

Do you chew tobacco, pan, use gutkha or supari now (or in the past)? _____

Please give any other details which your dentist might need to know about, such as self-prescribed medicines (eg aspirin)?

Completed by (please circle): 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



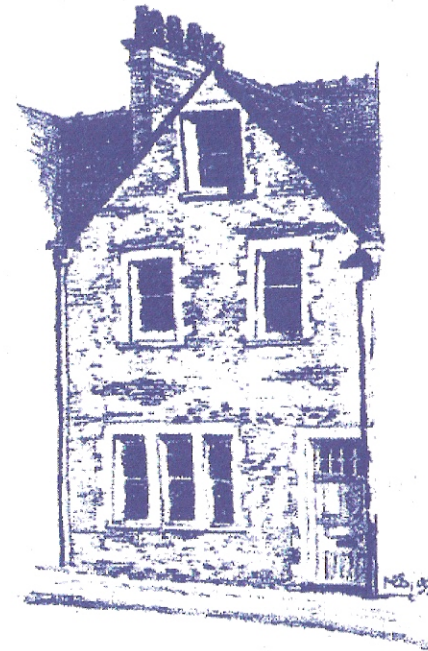
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DENTAL PRACTICE

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Oxon OX28 6HT

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Web: www.highstreetdentalpractice.co.uk
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Confidential Medical History Form

Like all dentists, we ask patients for information about their general health to help us treat them safely. Please write your contact details below, answer the health questions inside and then sign the form on the back page. We will show you the form at later visits so that you can tell us whether there has been any change in your general health. All information will be kept strictly confidential by the people caring for you.



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