CONFIDENTIAL MEDICAL HISTORY FORM

In order for us to provide the best and safest treatment, please complete this medical history form to the best of your knowledge. It will help us to tailor our services to your requirements.

Full Name:			
Address Line 1			
Town/City:			
County:		Post Code:	
Home Tel:		Mobile Tel:	
Email Address:			
Date of Birth:		Gender:	
Doctor's Name:			
Doctor's Address:			
Doctor's Tel:			
Last dental visit:			

ARE YOU CURRENTLY	YES	NO	PLEASE GIVE DETAILS
In good health?			
Attending or receiving treatment from a doctor, Hospital or Clinic?			
Taking any prescribed medicines? tablets, ointments, injections, HRT			
Taking or taken steroids in the last 2 years?			
Taking any blood thinning medication?			
Wearing a pacemaker?			
Pregnant or nursing mother?			
Carrying a medical warning card?			

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DO YOU SUFFER FROM	YES	NO	PLEASE GIVE DETAILS
Allergies to any medicines, (penicillin) substances, (latex) or foods (nuts)			
Hay fever or eczema?			
Bronchitis, Asthma, or any other chest conditions?			
Fainting attacks, giddiness, black-outs epilepsy?			
Heart conditions, angina, stroke, blood pressure problems?			
Diabetes? (or does anyone in your family?			
Arthritis or other bone or joint disease?			
Thyroid problems? (over or under active)			
Liver or Kidney disease? Or had Jaundice?			
Bruising or persistent bleeding following injury, tooth extraction?			
Any infectious diseases? (including HIV, Hepatitis B, C, or D)			

HAVE YOU EVER HAD	YES	NO	PLEASE GIVE DETAILS
Osteoporosis?			
Radiotherapy or Chemotherapy?			
A bad reaction to local or general anaesthetic?			
Blood refused by the Blood Transfusion service?			
A joint replacement or other implant?			
Cold sores?			
Rheumatic fever or chorea?			
Growth hormone treatment?			

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HAVE YOU EVER HAD	YES	NO	PLEASE GIVE DETAILS
Treatment that required you to be hospitalised?			
Heart or Brain surgery?			
Creutzfeldt Jakob Disease?			

DRINKING, SMOKING & CHEWING	YES	NO	PLEASE GIVE DETAILS
Do you drink any alcohol? If so, how many units do you drink per week?			(A unit is a half pint of lager, a single measure of spirits or a single glass of wine) Units/week
Do you smoke any tobacco products?			Times/day
Do you chew tobacco, paan, arecanut, supari or use gutkha?			

ADDITIONAL INFORMATION	YES	NO	PLEASE GIVE DETAILS
Do you think there are any other aspects, concerning your health that your dentist should know about?			
Do you have any communication support needs relating to a disability, sensory loss, or other impairment?			
Do you experience any problems when chewing?			
Are you happy with the overall appearance of your teeth?			
Do your gums ever bleed when you brush?			

How do you feel about going to the dentist? (Please circle)	Not anxious	Slightly anxious	Very anxious
How would you describe your diet? (Please circle)	Poor	Average	Excellent
How many times do you brush your teeth? (Please circle)	Once a day	Twice a day	After every meal
How often do you clean in between your teeth with floss or interdental brushes?	Daily	Every other day	Weekly

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COVID SCREENING QUESTIONS	YES	NO
Do you currently have a cough?		
Have you had a persistent dry cough in the last 14 days?		
Are you having shortness of breath or difficulty in breathing?		
Do you have a fever or felt feverish in the last 14 days?		

Patient Declaration completed by: (Please circle)			
Self	Parent	Guardian	Carer
I consent to the dental provider, or their representative, to examine me and to give me any necessary care and treatment that I am willing to undergo. I agree to pay the charges for the service I receive. I declare that the information I have given on this form is correct and complete to the best of my knowledge.			
Signature:			
Date:			

MEDICAL HISTORY TO BE UPDATED EVERY SIX MONTHS

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

Date	Record any changes	Patient's initials