

confidential medical history



smileessential
creating confidence

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

last name: _____ title: _____

first name: _____

date of birth: / / sex: male female

occupation: _____ how do you like to be addressed _____

address: _____

_____ postcode _____

home tel: _____ work tel: _____

mobile: _____ email: _____

in the event of an emergency, please contact

name: _____

telephone number: _____ relationship to you: _____

doctor's details

doctor's name: _____ telephone number: _____

address: _____

_____ postcode _____

who should we thank for recommending you to the practice? _____

when was your last visit to the dentist? _____



are you currently	yes / no	give details
receiving treatment from a doctor, hospital or clinic?	<input type="checkbox"/> <input type="checkbox"/>	
taking any prescribed medicines (eg tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?	<input type="checkbox"/> <input type="checkbox"/>	
carrying a medical warning card?	<input type="checkbox"/> <input type="checkbox"/>	
pregnant or possibly pregnant?	<input type="checkbox"/> <input type="checkbox"/>	

have you ever suffered from	yes / no	give details
allergies to medicines (eg penicillin), substances (eg latex/rubber) or foods?	<input type="checkbox"/> <input type="checkbox"/>	
bronchitis, asthma or other chest condition?	<input type="checkbox"/> <input type="checkbox"/>	
fainting attacks, giddiness, blackouts, epilepsy?	<input type="checkbox"/> <input type="checkbox"/>	
heart problems, angina, blood pressure problems, or stroke?	<input type="checkbox"/> <input type="checkbox"/>	
diabetes (or does anyone in your family)?	<input type="checkbox"/> <input type="checkbox"/>	
bone or joint disease?	<input type="checkbox"/> <input type="checkbox"/>	
bruising or persistent bleeding following injury, tooth extraction or surgery?	<input type="checkbox"/> <input type="checkbox"/>	
liver disease (eg jaundice, hepatitis) or kidney disease?	<input type="checkbox"/> <input type="checkbox"/>	
any other serious illness or infectious disease?	<input type="checkbox"/> <input type="checkbox"/>	



have you ever suffered from yes / no give details

blood refused by the blood transfusion service?	<input type="checkbox"/>	<input type="checkbox"/>	
a bad reaction to general or local anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>	
treatment that required you to be in hospital?	<input type="checkbox"/>	<input type="checkbox"/>	
heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	

alcohol

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/aperitif.)

_____ units per week

smoking

yes / no / in the 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 (did you in the past)?	_____ times per day

please give any other details which your dentist might need to know about, such as self-prescribed medicines (eg aspirin) or any disabilities you may have.

completed by (please tick)	self <input type="checkbox"/>	parent <input type="checkbox"/>	guardian <input type="checkbox"/>
patient signature: _____	date: _____		
dentist signature: _____	date: _____		



for official use only: please check that all the information on this form is still correct, record the review plus any changes below

date of review	if changes, please detail below	patient signature
any changes? yes <input type="checkbox"/> no <input type="checkbox"/>		dentist signature

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any changes? yes <input type="checkbox"/> no <input type="checkbox"/>		dentist signature

date of review	if changes, please detail below	patient signature
any changes? yes <input type="checkbox"/> no <input type="checkbox"/>		dentist signature

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any changes? yes <input type="checkbox"/> no <input type="checkbox"/>		dentist signature

