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| **MEDICAL HISTORY FORM** |
| TITLE: | FIRST NAME: | SURNAME: |
| DOB: |
| ADDRESS: |
| HOME TEL NO: | MOBILE: | WORK: |
| E-MAIL: |
| DOCTORS NAME & ADDRESS: |
| HOW LONG SINCE YOUR LAST DENTAL VISIT? |
| **ARE YOU?**  YES NO |
| Attending or receiving treatment from any doctor? (please give reasons) |  |  |
| Taking any medicines or tablets? If so please list overleaf. |  |  |
| Taking or have taken steroids in the last two years? |  |  |
| Allergic to any medicines, food or materials (please list)? |  |  |
| Likely to be pregnant? |  |  |
| **HAVE YOU?**  YES NO |
| Ever had jaundice, liver or kidney disease or hepatitis? |  |  |
| Ever had rheumatic fever or been told you have a heart murmur? |  |  |
| Ever been told you have a heart problem or had a heart attack? |  |  |
| Ever had infective endocarditis or heart valve replacement or any form of heart surgery? |  |  |
| High or low blood pressure? (please circle) |  |  |
| Had a blood test recently? |  |  |
| Ever had a bad reaction to a local or general anaesthetic? |  |  |
| Ever had a stroke? |  |  |
| Ever had a major operation or recently received hospital treatment? (please detail) |  |  |
| Ever had your blood refused by the blood transfusion service? |  |  |
| Ever been diagnosed or suspected as having CJD or HIV positive? |  |  |
| **DO YOU?** YES NO |
| Have a pacemaker? |  |  |
| Suffer from bronchitis or asthma? |  |  |
| Bruise easily or bleed excessively? |  |  |
| Have fainting attacks, giddiness or epilepsy? |  |  |
| Have diabetes? |  |  |
| Carry a warning card? |  |  |
| Drink alcohol? If so how many units a week? |  |  |
| Smoke? If so how many a day? |  |  |
| Know that smokers lose four times as many teeth through gum disease as non-smokers do? |  |  |
| Know that smoking and drinking alcohol significantly increase your risk of mouth cancer? |  |  |
| Do you become anxious or uncomfortable when receiving dental treatment? |  |  |
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| **NAME OF MEDICATION** | **REASON FOR TAKING** | **TODAYS DATE** |  |
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| **PLEASE INDICATE HOW YOU HEARD ABOUT US** |  |
| ONE STOP LOCAL |  | FAMILY/FRIEND |  | STREET SIGN |  |  |
| CHAD NEWSPAPER |  | WEBSITE/INTERNET |  | OTHER |  |  |
| **I declare that I have completed this medical history form to the best of my knowledge.****SIGNATURE: DATE:****PATIENT/PARENT/GUARDIAN**YOUR MEDICAL FORM NEEDS TO BE UPDATED EVERY 6 MONTHS- PLEASE CHECK YOUR DETAILS AND SIGN BELOW. (PLEASE MAKE ANY AMENDMENTS). |  |
| **SIGNATURE** | **DATE OF UPDATE** | **SIGNATURE** | **DATE OF UPDATE** |  |
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| Please give us your next of kin name and contact details. In case we needed to contact them in an emergency |  |  |
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