STRICTLY CONFIDENTIAL MEDICAL HISTORY FORM

To obtain the best and safest treatment, your dentist needs to know of any problems, which may affect your treatment

Surname:	**Mr, Ms, Miss, Mrs**	**Home Phone:**	**Work Phone:**
Forename:		**Mobile Phone:**	
Address:		**E-Mail Address:**	
		Occupation:	
Date of birth:		**Who/How referred?**	
Doctor's name and address:		**How long since last dental treatment?**	

ARE YOU	**YES**	**NO**	**DETAILS:**
Attending or receiving treatment from a Doctor, Hospital, Clinic or Specialist?			
Taking any medicines? Tablets, creams, ointments, injections or anything else?			
Taking Prozac, HRT, Steroids or **Cortisone.** **Have you ever taken** any of the above?			
Allergic to medicines, foods or other materials?			
HAVE YOU	**YES**	**NO**	**DETAILS:**
Had Rheumatic Fever or Chorea? (St Vitus Dance)			
Had Jaundice, Liver, Kidney disease, **Hepatitis** B or C?			
Ever been told you have a, **Heart problem**, Heart Murmur, Angina, Blood pressure or a Heart Attack?			
Ever had a bad reaction to general or local anaesthetic?			
DO YOU	**YES**	**NO**	**DETAILS:**
Have arthritis or Osteoporosis?			
Have a **pacemaker** or had any form of heart surgery?			
Smoke tobacco or E-Cigarettes?			
Suffer from bronchitis, asthma, chest or lung conditions?			
Have fainting attacks, dizzy spells, blackouts or epilepsy?			
Bruise easily or bleed enough to cause worry after a tooth extraction or other surgery or has any family member?			
Have Diabetes or does anyone in your family?			
Carry a warning card?			
Ever get cold sores?			
Have HIV or AIDS?			
Give permission for us to send text reminders?			
Are there any other aspects concerning your health that the Dentist should know about?			
Signature and Date:	**Completed by: Self / Parent / Guardian**		