**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** |