CONFIDENTIAL MEDICAL HISTORY SHEET

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

Surname Mr / Mrs / Miss ______________________________ Sex: Male / Female

Forename(s) ______________________________

Address ______________________________

______________________________ Postcode ______________

Tel No: Home ______________________ Work ______________________

E-mail ______________________________

Date of Birth ______________________ Occupation ______________________

When did you last receive dental treatment ______________________

Your Doctor's Name & Surgery ______________________

Are you currently	**Y**	**N**	**GIVE DETAILS**
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?			
Are you taking or have you taken steroids in the last 2 years?			
Carrying a medical warning card?			
Pregnant or a nursing mother?			

Do you suffer from	**Y**	**N**	**GIVE DETAILS**
Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?			
Hay fever or eczema?			
Bronchitis, asthma or other chest condition?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart problems, angina, blood pressure problems, or stroke?			
Diabetes (or does anyone in your family)?			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases (including HIV and hepatitis)?			

Please continue overleaf…

Did you, as a child or since, have:	Y	N	GIVE DETAILS
Rheumatic fever or chorea?			
Liver disease (e.g. jaundice, hepatitis) or kidney disease?			
Any other serious illness?			
Blood refused by the Blood Transfusion Service?			
A bad reaction to general or local anaesthetic?			
A joint replacement or other implant?			
Treatment that required you to be in the hospital?			
A pacemaker or have you had heart surgery?			
Brain surgery, growth hormone treatment before the mid 1980's or have a close relative with Creutzfeldt Jakob Disease?			

Drinking	**UNITS / WEEK**
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 and Chewing	**Y**	**N**	**IN PAST**	**QUANTITY**
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 (or 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)

Completed by (please circle) Self Parent Guardian

Signature ______________________________ **Date** ______________________________

Dentist Signature ______________________________ **Date** ______________________________