CONFIDENTIAL MEDICAL HISTORY FORM

TITLE:________ NAME:____ D.O.B:________________

ADDRESS:____

TEL.NO. HOME:____________________WORK:____________________ MOBILE:____________________

EMAIL ADDRESS:______________________________ OCCUPATION:______________________________

How would you like to be reminded of your appointment: Text ☐ Mobile ☐ Email ☐ Home ☐

Doctor's Name and address:____

Contact in case of emergency NAME:______________________________ TEL NO.:____________________

ARE YOU	YES	NO	DETAILS
Expectant Mother			
Attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Taking any medicines from your doctor?			
Taking or have taken steroids in the past two years?			
Have you had Bisphosphonates by infusion or tablets?			
Any allergies to medicines or materials e.g. antibiotics or latex?			

HAVE YOU:	YES	NO	DETAILS
Had Rheumatic fever?			
Had Jaundice, liver, kidney disease or hepatitis?			
Ever been told you have a heart murmur or heart problem, angina, high blood pressure or heart attack?			
Ever had a bad reaction to a local anaesthetic?			
Had a joint replacement or other implant?			
Been hospitalised? If YES for what and when?			

DO YOU	YES	NO	DETAILS
Have arthritis?			
Have a pacemaker?			
Suffer from hay fever, eczema, or any other allergy?			
Suffer from bronchitis, asthma, or any other chest condition?			
Have diabetes?			
Bruise easily or persistent bleed following injury, tooth extraction or surgery?			
Suffer from any infectious disease (including H.I.V)?			
Have a close relative with Creutzfeld Jakob Disease?			
Carry a warning card?			
Smoke? If yes, approximately how many each day?			
Drink alcohol? If yes, approximately how many units each week?			

Please give any other details which your dentist might need to know about, such as self-prescribed medicines (e.g. aspirin) or treatments or medicines that you prefer not to have for religious or personal reasons?

Signed by: Self / Parent / Guardian: **Date:**

Have there been any changes in your health since the last course of treatment?

Signature:	**Signature:**	**Signature:**	**Signature:**
Date:	**Date:**	**Date:**	**Date:**