**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** | | | |