# Confidential
# Medical History Form

| Title: | Surname: | First Name: |
|---|---|---|
| Date of Birth: | Profession: | Sex: F/M |
| Phone: | Mobile: | Landline: |

Your doctors name & address:

Your home address & postcode:

How long since you last visited a dentist? 6 months / Longer?

## Are You...

| | Yes | No |
|---|---|---|
| Attending or receiving treatment from any doctor? | | |
| Taking any medicines or tablets from your doctor? | | |
| Taking or have taken any steroids in the last two weeks? | | |
| Allergic to any medicines, foods or materials? | | |
| Likely to be pregnant? | | |

## Have You...

| | Yes | No |
|---|---|---|
| Ever had jaundice, Liver or Kidney disease or Hepatitis? | | |
| Ever had Rheumatic fever or been told that you have a heart murmur? | | |
| Ever been told that you have a heart problem or had heart attack? | | |
| Ever had infective endocarditis or a heart valve replaced or any form of heart surgery? | | |
| High or low blood pressure? | | |
| Had any blood tests recently? | | |
| Ever had a bad reaction to a local or general anaesthetic? | | |
| Ever had a stroke? | | |
| Ever had a major operation or recently received hospital treatment? | | |
| Ever had your blood refused by the Blood Transfusion Service? | | |
| Ever been diagnosed or suspected as having CJD or being HIV positive? | | |

## Do You...

| | Yes | No |
|---|---|---|
| Have a pacemaker? | | |
| Suffer from bronchitis or asthma? | | |
| Bruise easily or have you ever bleed excessively? | | |
| Have fainting attacks, giddiness or epilepsy? | | |
| Have diabetes? | | |
| Carry a warning card? | | |
| Smoke and if so how many a day? | | |
| Drink alcohol and if yes how many units a week? | | |

Confidential

# Medical History Form

BIRCHINGTON DENTAL CARE

## Emergency Contact

| Name: | Contact Number: | Relationship: |
| --- | --- | --- |

Are there any other aspects of your health that you feel we should know about?

Medicines / tablets / repeat prescriptions you take (if any):

Patient signature: ........................................ Date: ........................................

Dentist signature: ........................................ Date: ........................................

## Changes / Updates

Date:

| Date: | Changes | Patient initials | Dentist initials |
| --- | --- | --- | --- |
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