**MEDICAL HISTORY FORM**

**To obtain the best and safest treatment for you, your dentist needs to know all aspects of your health, which may affect your treatment. Please complete this form, which your dentist will discuss fully with you before commencing treatment.** If you have any questions, please ask your dentist. All information will be kept completely confidential. Thank you.

Title: Surname: Forenames: DOB:

Tel No: Mobile: Occupation:

Address & Postcode:

Doctors Name and Address:

Next of Kin and Contact Number

**GDPR (Your data): Are you happy to be contacted by (Please Tick as many as apply):** Phone Yes/ Text Message / E-mail

**Are you exempt from dental charges**: YES/NO **Expectant mother or breastfeeding:** YES/NO?

**Are you anxious about dental treatment?** Extremely A little anxious Not at All

|  |  |  |  |
| --- | --- | --- | --- |
| **ARE YOU CURRENTLY:** | **YES** | **NO** | **IF YES PLEASE GIVE DETAILS** |
| **Attending or receiving treatment from a doctor, hospital, clinic or an alternative therapist?** |  |  |  |
| **Taking any prescribed medicines?**  **(e.g. tablets, ointments, injections, inhalers, including contraceptives and/or hormone replacement therapy.)** |  |  |  |
| **Do you carry a warning card?** |  |  |  |
| **DO YOU SUFFER FROM:** | **YES** | **NO** | **IF YES PLEASE GIVE DETAILS** |
| **Allergies to any medicines?**  **(e.g. antibiotics, substances such as latex or any foods.)** |  |  |  |
| **Hay fever or eczema?** |  |  |  |
| **Cold sores?** |  |  |  |
| **Fainting attacks, giddiness, blackouts, epilepsy?** |  |  |  |
| **Diabetes or does anybody in your family?** |  |  |  |
| **Arthritis?** |  |  |  |
| **Bruising or persistent bleeding following injury, tooth extraction or surgery?** |  |  |  |
| **Any infectious disease (including HIV or Hepatitis?)** |  |  |  |

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| **DID YOU, AS A CHILD OR SINCE HAVE:** | **YES** | **NO** | **IF YES PLEASE GIVE DETAILS** |
| Rheumatic fever or chorea (St Vitas Dance)? |  |  |  |
| Liver disease (e.g. jaundice, hepatitis, kidney disease) |  |  |  |
| Any other serious illness? |  |  |  |
| Blood refused by the blood transfusion service? |  |  |  |
| Regular blood tests or inoculations? |  |  |  |
| A bad reaction to general or local anaesthetic? |  |  |  |
| A joint replacement or other implant? |  |  |  |
| Treatment that required you to be in hospital? |  |  |  |
| Heart surgery, angina, blood pressure problems or stroke? |  |  |  |
| Brain surgery? |  |  |  |
| Growth hormone treatment before the mid 1980’s ? |  |  |  |
| A close relative with Creutzfeldt Jakob Disease? |  |  |  |

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| **SMOKING AND DRINKING ALCOHOL** | **YES** | **NO** | **IF YES PLEASE GIVE DETAILS** |
| **Do you Drink Alcohol? If so how many units per week. A unit is half a pint of larger, a single measure of spirit, or 1 glass of wine/aperitif** |  |  |  |
| **Do you smoke any tobacco products now or in the past?** |  |  |  |
| **Do you chew tobacco, pan or supari now or in the past?** |  |  |  |
| **Do you want to give up smoking?** |  |  |  |

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| Please give any other details which your dentist may need to know, such as self prescribed medications e.g. Asprin. |  |
|  | **DATE: SIGN:** |