

# Medical History

Title:………Forenames:…………….........Surname:………………………….

Sex: Male/Female Date of Birth:………………………..........

Address:…………………………………………………………………………..

…………………………………………………………Postcode…..……………

Telephone: Home:………………. Work:……………… Mobile:………........

Email:(Please Print)………………………………………………………………

Occupation:……………………………………………………………………….

Date of last dental treatment::……...........……………………………………..

How did you hear about the practice:.................…………………………….

Doctors Name (GP)……………..…………………………………………........

Doctors Address (GP)……………………………………………………….......

…………………………………………………………………………………......

Doctor’s telephone (GP)…………………………………………………….......

NHS Number:............................................................................................

If you are entitled to free NHS dental services please tick the relevant box:

 Under 18 Years of Age 18 years and in Full time Education

 Pregnant Had a baby in last 12 months Income Support

 Income Based Jobseekers Allowance Pension Credit

 Income Related Employment & Support Allowance HC2 Certificate

 NHS Tax Credit Exemption Certificate (Card) HC3 Certificate

If you do not wish to receive any information from us please tick the box:

**Are you currently?**

Pregnant? Yes No

Receiving treatment from a doctor, Hospital or clinic?

Details:……………………………………. Yes No

Taking any prescribed medicines? Yes No

Details:…………………………………….

Carrying a medical warning card? Yes No

**Do you suffer from?**

Allergies to any medicines or substances? Yes No

Details:……………………………………

Hayfever or eczema?

Details:…………………………………… Yes No

Bronchitis, asthma or other chest condition?

Details:……………………………………. Yes No

Fainting attacks, giddiness, blackouts

Or epilepsy? Yes No

Heart problems, angina, blood pressure or stroke Yes No

Diabetes (or does anyone in your family)?

Details:…………………………………….. Yes No

Arthritis? Yes No

Bruising or persistent bleeding following injury,

Tooth extraction or surgery? Yes No

Any infectious diseases (including HIV or hepatitis)? Yes No

**Did you, as a child or since have:**

Rheumatic fever or chorea? Yes No

Liver disease (eg: jaundice, hepatitis)

Or kidney disease? Yes No

Any other serious illness? Yes No

A bad reaction to general or local anaesthetic? Yes No

A joint replacement or other implant? Yes No

Treatment that required you to be in hospital? Yes No

Details:…………………………………………

Heart surgery? Yes No

Brain surgery? Yes No

Growth hormone treatment before the mid 1980’s? Yes No

A close relative (parent, sibling, child, grandparent

Or grandchild) with Creutzfeldt Jakob Disease? Yes No

# Drinking

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)

# Smoking and Chewing

Do you smoke any tobacco products now (or did you in the past)?

How many times per day?

Please give any other details, which your dentist might need to know about?.........................................................................................................

………………………………………………………………………………………

Completed by: Self Parent Guardian

Patient’s Signature:…………………………. Date:…./…./….

Dentist’s Signature:…………………………. Date:…./…./….

**Medical History Update**

Please check that the health information on this form is still correct. If not, note changes below.

|  |  |  |
| --- | --- | --- |
| Date | Changes to Medical History Since Last Visit | Signature |
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