CONFIDENTIAL MEDICAL HISTORY FORM

To obtain the best and safest dental treatment, your dentist needs to know of any problems that may affect your treatment.

Name: _____ Date of birth: ____ / ____ / ____

Address: _____ Postcode: _____

Telephone number: Home / work☎ _____ Mobile ☎ _____ ; Occupation: _____

Email Address:_____

Next of Kin (with contact details): _____

Last Dental Visit (if a new patient) : __ / __ Nervous of visiting a dentist?: Yes / No

Do you smoke – **Yes / No**. Do you drink alcohol: **Yes** ____units/week / **No**

Your Doctor's name & address:

	Yes ✓	No ✕	Further Details
1. Are you aware of anything that you are **allergic** to? (penicillin or another antibiotic, pollen, latex, food, jewellery or any other substance)	----	----	
2. Have you ever had any heart problems/conditions? (blood pressure problems, angina or chest pains, pacemaker or any other heart or blood vessel condition)	----	----	
3. Have you ever had any chest or breathing problems/conditions? (asthma, bronchitis or any other breathing problems)	----	----	
4. Have you ever had any stomach, gut, liver or kidney problems/conditions?	----	----	
5. Do you have any blood or **bleeding problems/conditions**?	----	----	
6. Are you prone to fits/faints or do you have epilepsy?	----	----	
7. Do you have any problems or conditions relating to your bones, joints or muscles? (arthritis, muscle weakness or any other condition)	----	----	
8. Do you have hepatitis, HIV, AIDS or tuberculosis (TB)?	----	----	
9. Are you **pregnant** or is there a **possibility you could be pregnant**?	----	----	
10. Do you have diabetes?	----	----	
11. Do you have a medical condition or problem not specified above?	----	----	
12. Are you **currently under treatment** from a doctor, consultant or clinic?	----	----	
13. Do you carry a medical warning card?	----	----	
14. Are you **taking or meant to take medicine** prescribed by your doctor or otherwise? (tablets, pills, patches, medicines, inhalers, ointments, injections, oral contraceptives, herbal remedies, recreational drugs, recent vaccinations). If yes, please enter them in the 'Further Details' box	----	----	
15. Are there any conditions that run in your family? (diabetes, sickle cell disease or any other conditions). If yes, please enter them in the 'Further Details' box.	----	----	
16. Have you ever had an illness or operation that required hospital treatment? If yes, please enter them in the 'Further Details' box.	----	----	

Additional Requirements or Special Needs (Please tick appropriate box/s)

☐ Visual impairment ☐ Hearing difficulties ☐ Learning difficulties ☐ Communication difficulties ☐ Mental health difficulties ☐ Physical disability ☐ Wheelchair user ☐ None ☐ Other (Please give details if appropriate) _____

Thank you. If there is anything you are unsure about please ask the dentist

Please indicate your consent by ticking (✓) the relevant boxes:

- The **Practice Privacy Policy** is available at reception and the practice website www.dentallyyours.uk
- We like to send out Dental Healthcare Newsletters. Would you like to receive such communication by ☐ **post** ☐ **email** ☐ **Text message** ☐ **Phone call** ☐ **No, I would not like to receive any Newsletters**

Completed by: Self / Parent / Guardian / Carer Signature ……

If filling for someone else, please print your name …… Date ……