Confidential Medical History Form

Dentist on The Green

We ask you for information about your general health to help us treat you safely. All information will be kept strictly confidential by the people caring for you.

Surname: Forename: Title	Address:_____ _____ _____ Postcode:_____
Date of Birth:	Tel (home):
Occupation:	Mobile: (text reminder)
Last visit at the Dentist:	Tel (work)
Your doctor's name & address: _____ _____	Email:

Are you currently:	**Y**	**N**	**If you have answered Yes, please provide details :-**		
Receiving any Medical treatment?	◉	○			
Take any regular / prescribed medication?	○	○			
Pregnant / possible pregnant?	○	○			
Carrying a medical warning card?	○	○			
Have you ever suffered from:	**Y**	**N**		**Y**	**N**
Allergies to any medication / substances (e.g. antibiotics or latex) or food?	○	○	Any infectious diseases including HIV or Hepatitis?	○	○
Diabetes	○	○	Heart problems, angina, blood pressure problems, stroke or pacemaker?	○	○
Allergies (hay fever	○	○	A bad reaction to general or local anaesthetic?	○	○
Fainting attacks, giddiness, blackouts or Epilepsy?	○	○	Rheumatic Fever or Chorea (St Vitus Dance)?	○	○
Bronchitis, Asthma or other chest condition?	○	○	Liver disease (e.g Jaundice, Hepatitis) or kidney disease?	○	○
Arthritis?	○	○	Any other serious illness or infectious disease?	○	○
Bruising or persistent bleeding following injury, tooth extraction or surgery	○	○	Blood refused by the Blood Transfusion Service?	○	○
A joint replacement or implant	○	○	Do you use tobacco products? If so how many per week?	○	○
Treatment that required you to be in hospital	○	○	Do you consume alcohol? If so how many units per week?	○	○
Heart surgery	○	○	Do you use recreational drugs?	○	○
Brain surgery	○	○	Recent trips abroad? If so, where?	○	○

Do you take medication on a regular basis? Please bring your repeat prescription.	**Y**	**N**	Do you have family members at this practice?	**Y**	**N**
Wafarin	◯	◯	**How did you hear about us?**		
Blood Pressure Tablets	◯	◯	Friend / Family	☐	
Diabetes	◯	◯	Sigh Outside	☐	
Asprin	◯	◯	Leaflet / Flyer	☐	
Inhalers	◯	◯	Online Search	☐	
Other:	◯	◯	Facebook	☐	
			Other:	☐	
			How would you prefer to be contacted?		
			Phone Call		
			Email		
			Text		

Completed by: Self ◯ Parent / Guardian ◯

Signature:_____ Date:_____

Medical History Update: Have there been any changes in your health, medicines, injections or tablets since your last course of treatment?

Patient Update of Medical History

Date:		Date:		Date:		Date:		Date:		Date:	
Sign.		Sign.		Sign.		Sign.		Sign.		Sign.	
Dentist Signature.											
Sign.		Sign.		Sign.		Sign.		Sign.		Sign.	

Marketing - Please read & Sign

From time to time we would like to contact you if we have any offers or reduction in treatment prices; these may include Teeth Whitening, Orthodontic, Crowns, Hygiene. (You can withdraw consent at any time).

Do you agree to receive these offers? **Y** ◯ **N** ◯

Signature _____

Submit Form