CONFIDENTIAL MEDICAL HISTORY

For your well being you must inform us of any medical changes that have occurred since your last visit. *Please ensure that you keep us up to date with all the medications that you are taking.*

Like all dentists, we ask patients for information about their general dental health to help us treat them safely. *Please write your contact details below and answer the health questions listed. We will show you the form at later visits so that you can tell us whether there has been any change in your general health.*

Your Details

Title: Mr / Mrs / Miss / Ms	Other
Surname	Forenames
Address Post Code	Work Number
	Home Number
Date of Birth	Mobile Number
Doctors Name	Email
Doctors Address	NHS Number
	Occupation

A. Are You

1. Attending or receiving any treatment from your doctor, hospital, clinic or specialist?	YES/NO
2. Taking any medicines or tablets prescribed by your doctor? *(Please list all medications or attach a copy of your repeat prescription)*	YES/NO
3. Allergic to penicillin or any other drug or substance?	YES/NO
4. Pregnant or likely to be so?	YES/NO

B. Have You

1. Ever had a heart problem, angina, high or low blood pressure, heart attack or stroke?	YES/NO
2. Ever had rheumatic fever?	YES/NO
3. Ever had jaundice, hepatitis, liver problems or kidney disease?	YES/NO
4. Ever had asthma, bronchitis or any serious chest infections?	YES/NO
5. Ever had any blood refused by the blood transfusion service or blood related diseases? *Eg. HIV or Hepatitis?*	YES/NO
6. Ever had a bad reaction to local or general anaesthetic?	YES/NO
7. Ever had an operation or received hospital treatment?	YES/NO
8. Ever had a heart valve replaced?	YES/NO
9. Ever been diagnosed as having CJD? *(or has any member of your family)*	YES/NO

CONTINUED OVERLEAF

CONFIDENTIAL MEDICAL HISTORY CONTINUED

C. Do You

1. Have a pacemaker?	YES/NO
2. Have fainting attacks, giddiness or epilepsy?	YES/NO
3. Have diabetes?	YES/NO
4. Have arthritis?	YES/NO
5. Suffer from hayfever or eczema?	YES/NO
6. Carry a warning card?	YES/NO
7. Bruise easily or do you bleed excessively?	YES/NO
8. Take or have you ever taken steroids?	YES/NO
9. Drink? If so, how much?	YES/NO
10. Smoke? If so, how much?	YES/NO
11. Chew Betel Nut? If so, how much?	YES/NO

Completed by *(please tick)*

☐ Self ☐ Parent ☐ Guardian ☐ Dentist

Patient Signature

Date / /

Medical History Update

Please check that the health information given in this form is still correct (including information on smoking and drinking). Please amend as necessary.

Date / / Patient Signature

Date / / Patient Signature

Date / / Patient Signature

Date / / Patient Signature

Date / / Patient Signature

Additional notes/comments

CAPE HOUSE DENTAL PRACTICE