Confidential Medical History

Please fill in your details:

Name: **DOB:** **GP Practice Name:**

Address: **Postcode:** **Occupation:**

Home Phone: **Mobile:** **Email:**

Emergency/Next of kin details:

Certain medical conditions can affect dental treatment. Please complete this form by circling yes or no to the following questions, providing details where appropriate.

Are you:	Please circle	Details
Attending or receiving treatment from a hospital, clinic, doctor or specialist, if yes, what for?	Yes/ No	
Taking any pills, tablets or medicines, if yes what are they?	Yes/ No	
Pregnant or Nursing mother?	Yes/ No	
Allergic to any medicines, foods, or materials? E.g. penicillin or latex	Yes/ No	
Carry a medical warning card	Yes/ No	
Currently or previously taking steroids?	Yes/ No	

Smoking and Drinking	Please circle	Details
Do you smoke/chew and tobacco products now or did you in the past, if yes how many?	Yes/ No	**Amount per day?**
Do you drink alcohol? If yes how many units do you drink per week? (1 unit= ½ pint of lager or a small glass of wine)	Yes/ No	

Have you ever suffered from:	Please circle	Details
Any heart complaint/ heart surgery?	Yes/ No	
Angina, stroke or rheumatic fever?	Yes/ No	
Diabetes?	Yes/ No	
Epilepsy or fainting attacks?	Yes /No	
Any chest problems e.g. asthma, COPD?	Yes/ No	
Liver or kidney disease?	Yes/ No	
Excessive bleeding?	Yes/ No	
High blood pressure or DVT?	Yes/ No	
Any infectious disease? (including HIV and Hepatitis)	Yes/ No	
Osteoporosis?	Yes/ No	
Any other serious illness?	Yes/ No	

This form was completed by:

Name: **Signed:**

Dentist Signature: **Date:**