http://www.dental-elements.co.uk
Tel: 0151 424 7507

CONFIDENTIAL MEDICAL HISTORY FORM

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

NAME:	
DATE OF BIRTH:	GENDER: MALE / FEMALE
ADDRESS:	
TEL NO (HOME):	(WORK):
TEL NO (MOBILE):	EMAIL:
HOW LONG SINCE LAST DENTAL VISIT: (Please estimate if you are unsure)	OCCUPATION:
YOUR DOCTOR'S NAME AND ADDRESS:	
Please provide us with the contact details of your NEXT OF KIN, or anyone else whom you give us permission to contact in case of emergency. Please state their relationship to you e.g. spouse, son/daughter, friend:	

ARE YOU	YES	NO	GIVE DETAILS
Currently pregnant or is there any chance that you could be?			
Attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Taking any medicines from your doctor? (Tablets, creams, ointments, injections). Please list any medication. Continue overleaf if necessary.			
Taking or have you taken steroids in the last two years?			
Allergic to any medicines (e.g. Penicillin) substances (e.g. latex) or foods?			

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HAVE YOU…	YES	NO	GIVE DETAILS
Had rheumatic fever or chorea (St Vitus Dance)?			
Had jaundice, liver, kidney disease or hepatitis?			
Ever been told you have a heart murmur or heart problem, angina, blood pressure, heart attack?			
Had any blood test, inoculations recently?			
Ever had your blood refused by the Blood Transfusion Service?			
Had a bad reaction to a general or local anaesthetic?			
Had a joint replacement?			
Have you had treatment in hospital recently that may affect your dental treatment?			
DO YOU…	**YES**	**NO**	**GIVE DETAILS**
Have arthritis?			
Have a pacemaker, or have you had any form or heart surgery?			
Suffer from hay fever, eczema or any other allergy?			
Suffer from bronchitis, asthma or any other chest condition?			
Have fainting attacks, giddiness, blackouts or epilepsy?			
Have diabetes?			
Bruise easily or suffer from persistent bleeding following injury, tooth extraction or surgery?			
Carry a medical warning card?			

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DO YOU…	YES	NO	GIVE DETAILS
Drink alcohol? If yes, approximately how much per week?			
Do you smoke? If yes, please state how many cigarettes you smoke on average per day and how long you have smoked for.			
Are there any other aspects concerning your health that you think the dentist should know about?			

Completed by: Self/Parent/Guardian

Signature (**Dentist**):……

Signature (**Patient**):…….

Date:……

CONSENT TO CONTACT YOU

From time to time we may need to get in contact with you, for example to remind you of or discuss a scheduled appointment, to discuss your treatment or to remind you your routine examination is due. We may do this via telephone, post, email or text message. Please sign below to give us your permission for us to do this. You may later withdraw your permission at any time:

Signature:…….