Confidential Medical History Form

STRICTLY CONFIDENTIAL

Welcome to Hockley Dental Surgery. You will shortly be going through to see your dentist/hygienist. Before you do, we ask that you take a few moments to complete the questions on this form.

Full Name:					
Title:		Date of Birth:		Sex:	*Male / Female*
Home Address:					
			Postcode:		
Home Tel:			Mobile Tel:		
Email Address:					
Occupation:					
Doctors Name & Address:					
			Doctors Tel:		

Are you currently?	*Yes*	*No*	*If 'Yes', please provide as much detail as possible*
Attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Taking or have taken steroids in the last 2 years?			
Carrying a medical warning card?			
Taking any blood thinning medication such as Warfarin or Aspirin? *Please specify and give your most recent **INR** if applicable.*			
Taking or have taken bisphosphonates in the last 10 years? *(e.g. alendronic acid)*			
Wearing a pacemaker?			

Do you suffer from?	*Yes*	*No*	*If 'Yes', please provide as much detail as possible*
Allergies to any medications (e.g. penicillin), substances (e.g. latex/rubber) or foods (e.g. nuts/shellfish)?			
Hay fever or eczema?			
Asthma? How severe? Do you use inhalers?			
Bronchitis, emphysema, COPD, other lung/chest condition?			
Epilepsy, fainting attacks, giddiness, blackouts?			
Heart conditions, angina, strokes? Heart surgery?			
Diabetes? Type 1 or type 2? Medications taken?			
High/low blood pressure? Medications taken?			
Arthritis or other bone/joint disease?			
Thyroid Problems? (over or underactive)			
Liver or kidney disease? Jaundice?			
Any infectious diseases? (E.g. HIV, Hepatitis B, C or D, HPV)?			

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Have you ever had?	*Yes*	*No*	*If 'Yes', please provide as much detail as possible*
Osteoporosis?			
Radiotherapy or chemotherapy?			
A bad reaction to local or general anaesthetic?			
Excessive bleeding after cuts, injuries or dental extractions?			
Cold sores?			

Alcohol Consumption	
How many units of alcohol do you drink per week? (One unit is half a pint of lager, a single measure of spirit or a single glass of wine)	

Smoking/Tobacco	*Yes*	*No*	*In the past*	*Number per day?*	*Years smoked?*
Do you/have you ever smoked any tobacco products?					
Do you/have you ever chewed tobacco?					

Women Only	*Yes*	*No*	*If 'Yes', please provide as much detail as possible*
Is there any possibility you may be pregnant?			
Have you had a baby in the last 12 months?			
Are you currently breast-feeding?			

List of prescription medications (please attach a prescription list if necessary)

Medication Name	*Dose*	*Number of times per day*	*What is the medication for?*

Print Name:	Signature:	Date:

Patient / Parent / Guardian (Delete as applicable)

The section below is to be completed by a qualified member of staff only:

UPDATED:

Date	Changes?	Checked By	Signed