Completed by (please tick) Self ☐
Parent ☐
Guardian ☐

Patients Signature

_____ Date _____

Dentist Signature

_____ Date _____

Medical history update
Please check all information is still correct

Date	No change	List any changes	Patients initials

Confidential Medical History Form

Patients Name _____

Title _____

Sex Male ☐ Female ☐

Date of Birth _____

Address _____

_____

Telephone Home _____
Mobile _____

In the event of an emergency, please contact:
Name _____
Number _____

Email _____

Occupation _____

Doctors name and address _____

_____

Doctors telephone number _____

Are you currently

	Yes	No	Give details
Receiving treatment from a doctor, hospital or clinic?	☐	☐	
Taking any perscribed medicines (eg tablets, injections or inhalers)?	☐	☐	
Carrying a medical warning card?	☐	☐	
Pregnant or possibly pregnant?	☐	☐	
Have any infectious diseases, HIV,CJD or Hepatitis	☐	☐	

Have you ever suffered from

	Yes	No	Give details
Allergies to medicines or any substances (eg. Penicillin / latex/ foods)?	☐	☐	
Bronchitis, asthma or any other chest condition?	☐	☐	
Fainting attacks, giddiness, blackouts, epilepsy?	☐	☐	
Heart problems, angina, blood pressure problems, or stroke?	☐	☐	
Diabetes (or anyone in your family)?	☐	☐	
Bone or joint disease?	☐	☐	
Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐	☐	
Liver disease (eg jaundice, hepatitis) or kidney disease?	☐	☐	
Any other serious illness or infectious disease?	☐	☐	
Blood refused by the Blood Transfusion Service?	☐	☐	
A bad reaction to general or local anaesthetic?	☐	☐	
Treatment that required you to be in hospital?	☐	☐	
Heart surgery?	☐	☐	

How many unit of alcohol do you drink per week? (a unit is half a pint of larger, a single measure of spirits or a single glass of wine)

_____ Units per week

Tobacco use

Do you smoke any tobacco products?

Yes **No** **In the past** _____ Times per day

Do you chew tobacco, pan, use gutkha or supari?

Yes **No** **In the past** _____ Times per day

Please give any other details which your dentist may need to know about. Such as self-prescribed medicines (eg asprin) or any disabilities.