THE TOOTH TEAM

CONFIDENTIAL MEDICAL HISTORY FORM

We ask you for information about your general health to help us treat you safely. Please fill in your contact details, answer fully the health questions and sign the form. We will use the information on this form at later visits to discuss any changes in your general health. All information will be kept strictly confidential by the people caring for you.

Title: _____ First Name(s): _____Surname :_____

Date of Birth: _____ Gender: Male / Female Occupation: _____

Home Address: _____

_____ Postcode: _____

Phone: Home: _____ Work: _____ Mobile: _____

Email Address: _____ Last Dental Visit: _____

Doctor's Name: _____ Doctor's Address: _____

_____ Doctor's Phone: _____

How did you hear about the practice? Website / Google / Yellow pages / Phone Book / Walked past / Word of Mouth _____ / Other _____

Are you?	**Yes**	**No**	**Details**
Attending or receiving treatment from a doctor, hospital, clinic,specialist? If so for what?			
Taking any medicines from your doctor? **Please list over the page.**			(include all tablets, ointments, inhalers, injections, contraceptives, HRT.)
Taking any self- prescribed drugs?			
Allergic to any medicines (eg. penicillin), materials (eg. Latex), or foods.			
Pregnant or trying to conceive?			
Have you?			
Had a serious illness or operation in the last 5 years?			
Taken Steroids in the last 2 years?			
Had Bisphosphonate therapy? If so, for how long?			
Had a Malignant disease, Chemotherapy or Radiotherapy or bone marrow transplant?			
Had Jaundice, liver disease or hepatitis?			
Had any recent blood tests or inoculations?			
Had a bad reaction to local anaesthetic?			
Ever been told you have a heart problem. Such as a murmur, angina, high blood pressure, heart attack, infective endocarditis?			
Suffer from/are suffering from an infectious disease?			

Have you?	Yes	No	Details
Ever had a stroke or TIA ?			
Do You?			
Experience chest pain on exertion or at rest?			
Have heart palpations without exertion?			
Have a Pacemaker or Stents?			
Bruise easily or have tendency to bleed after injury or surgery?			
Do you have fainting attacks, giddiness, blackouts or Epilepsy?			
Carry a warning card / medical alert band?			
Suffer from Bronchitis, Asthma or other Lung problem?			
Have Diabetes?			
Have Thyroid disease?			
Have Kidney disease?			
Have Arthirits?			
Have any Neurological problems? Such as Multiple Sclerosis, Parkinson's disease or other.			
Smoke? If so, how many / much a day?			
Drink Alcohol? If so how many units a week?			
Do you have any other health problems not listed above?			
Are there any other aspects concerning your health that you think the dentist should know about?			

Please detail in this section, ANY drugs you are currently taking.

Drug	Dose	Frequency Taken

Completed by:	Signature:	Date:
If you are signing on behalf of someone, please state your relationship (parent / guardian / carer)		

Have there been any changes in your health / medicines since you last attended?

Details	Signed	Date

Please detail in this section, ANY drugs you are currently taking.

Drug	Dose	Frequency Taken

Completed by:	Signature:	Date:
If you are signing on behalf of someone, please state your relationship (parent / guardian / carer)		