

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?			

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