

Your dentist needs to know the answers to the following questions.

SURNAME: .....	TITLE: .....
FIRST NAMES: .....	DATE OF BIRTH: .....
SEX: Male <input type="checkbox"/> Female <input type="checkbox"/>	OCCUPATION: .....
CURRENT ADDRESS: .....	WORK ADDRESS: .....
.....	.....
.....	.....
TEL NO: .....(home)	TEL NO: .....(work)
(mobile) .....	EMAIL: .....
YOUR DOCTOR'S NAME & ADDRESS .....	

<b>Are you:</b>	<b>Yes</b>	<b>No</b>	<b>Details</b>
1. Attending or receiving treatment from a Doctor, Hospital clinic or specialist?	<input type="checkbox"/>	<input type="checkbox"/>	.....
2. Taking any prescribed medicines (eg.tablets,ointments, injections, inhalers – including contraceptives or HRT)?	<input type="checkbox"/>	<input type="checkbox"/>	.....
3. Taking or have taken steroids in the last two years?	<input type="checkbox"/>	<input type="checkbox"/>	.....
4. Allergic to any medicines, foods or materials (eg. latex or rubber)?	<input type="checkbox"/>	<input type="checkbox"/>	.....
5. Pregnant or have you had a baby within the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	.....
<b>Have you:</b>	<b>Yes</b>	<b>No</b>	<b>Details</b>
1. Had rheumatic fever or chorea (St.Vitus Dance)?	<input type="checkbox"/>	<input type="checkbox"/>	.....
2. Had jaundice, liver, kidney disease or hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	.....
3. Ever been told that you have a heart murmur or Heart problem, angina, blood pressure or had heart attack?	<input type="checkbox"/>	<input type="checkbox"/>	.....
4. Had any blood tests, inoculations etc?	<input type="checkbox"/>	<input type="checkbox"/>	.....
5. Had your blood refused by the Blood Transfusion Service?	<input type="checkbox"/>	<input type="checkbox"/>	.....
6. Had a bad reaction to a general or local anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>	.....
7. Had a joint replacement?	<input type="checkbox"/>	<input type="checkbox"/>	.....
8. Ever had brain surgery?	<input type="checkbox"/>	<input type="checkbox"/>	.....
9. Had growth hormone treatment before the mid 1980s?	<input type="checkbox"/>	<input type="checkbox"/>	.....
10. Been hospitalised? If “yes” what for and when?	<input type="checkbox"/>	<input type="checkbox"/>	.....
11. Had a close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease?	<input type="checkbox"/>	<input type="checkbox"/>	.....

<b>Do you:</b>	<b>Yes</b>	<b>No</b>	<b>Details</b>
1. Ever get cold sores?	<input type="checkbox"/>	<input type="checkbox"/>	.....
2. Have arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	.....
3. Have a pacemaker, or have you had any form of heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	.....
4. Suffer from hay fever, eczema or any other allergy?	<input type="checkbox"/>	<input type="checkbox"/>	.....
5. Suffer from bronchitis, asthma or other chest condition?	<input type="checkbox"/>	<input type="checkbox"/>	.....
6. Have fainting attacks, giddiness, blackouts or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	.....
7. Have diabetes or does anyone in your family?	<input type="checkbox"/>	<input type="checkbox"/>	.....
8. Bruise easily? Or following tooth extraction, surgery or injury, do you or your family bleed so as to cause concern?	<input type="checkbox"/>	<input type="checkbox"/>	.....
9. Carry a warning card?	<input type="checkbox"/>	<input type="checkbox"/>	.....
10. Have any infectious diseases (including HIV or hepatitis)?	<input type="checkbox"/>	<input type="checkbox"/>	.....
11. Suffer from any other serious illness?	<input type="checkbox"/>	<input type="checkbox"/>	.....

<b>Drinking</b>	<b>Number of Units</b>
How many units of alcohol do you drink per week? (eg.one unit is half a pint of lager, a single measure of spirit or a small glass of wine / aperitif	.....

<b>Smoking and Chewing</b>	<b>Yes</b>	<b>No</b>	<b>Previously</b>	<b>Quantity (per day):</b>
Do you smoke any tobacco products now or did you in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Do you chew tobacco, pan or supari now or did you in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....

Please give any details which your dentist may need to know, such as homeopathic remedies, self-prescribed medicines (eg.aspirin) or any other aspects of your health:

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By signing this Medical History Form you consent to the disclosure of your dental notes and other records for the purpose of any review, assessment or consideration of the care provided by your dentist, which may take place in the fulfilment of the Clinical Governance Policy but not for any other purpose without further consent.

We thank you for taking your time to complete this form!

Completed by Self / Parent / Guardian / On behalf of Patient:
Signature: ..... Print Name: ..... Date: .....