

# Confidential Medical History Form

Like all dentists, we ask patients for information about their general health to help us treat them safely. Please write your contact details below, answer the health questions and then sign the form on the back page. We will ask when you visit so that you can tell us whether there has been any change in your general health. All information will be kept strictly confidential by the people caring for you.

Surname  Forenames  Title

Sex  Male  Female Date of birth  Day  Month  Year

Address

Postcode

Telephone (home)  (work)  (mobile)

Occupation  email

Doctor's name and address

Doctor's telephone

**1. ARE YOU CURRENTLY**

	Yes	No
Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Receiving treatment from a doctor, hospital or clinic?	<input type="checkbox"/>	<input type="checkbox"/>
Taking prescribed medicines (eg tablets, ointments, injections or inhalers, including contraceptives and hormone replacements)?	<input type="checkbox"/>	<input type="checkbox"/>
Carrying a medical warning card?	<input type="checkbox"/>	<input type="checkbox"/>

**2. DO YOU SUFFER FROM**

	Yes	No
Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever or eczema?	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis, asthma or other chest condition?	<input type="checkbox"/>	<input type="checkbox"/>
Fainting attacks, giddiness, blackouts or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems, angina, blood pressure problems, or stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (or anyone in your family)?	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
Bruising or persistent bleeding following injury, tooth extraction or surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Any infectious diseases (including HIV and hepatitis)?	<input type="checkbox"/>	<input type="checkbox"/>

**3. DID YOU, AS A CHILD OR SINCE, HAVE?**

	Yes	No
Rheumatic fever or chorea?	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease (eg jaundice, hepatitis), or kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>
Any other serious illness?	<input type="checkbox"/>	<input type="checkbox"/>

**4. DID YOU, AS A CHILD OR SINCE HAVE**

	Yes	No
Blood refused by the Blood Transfusion Service?	<input type="checkbox"/>	<input type="checkbox"/>
A bad reaction to a general or local anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>
A joint replacement or other implant?	<input type="checkbox"/>	<input type="checkbox"/>
Treatment that required you to be in hospital?	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery/Brain Surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Growth hormone treatment before mid 80s?	<input type="checkbox"/>	<input type="checkbox"/>
A close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease?	<input type="checkbox"/>	<input type="checkbox"/>

**5. DRINKING**

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

**6. SMOKING AND CHEWING**

	Yes	No	In Past
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, use gutkha or supari now (or did you in the past)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**8. PLEASE GIVE ANY OTHER DETAILS WHICH YOUR DENTIST MIGHT NEED TO KNOW ABOUT, SUCH AS SELF-PRESCRIBED MEDICINES (EG ASPIRIN)?**



# WELCOME TO ABBEYMEAD DENTAL CENTRE

Please answer these **optional** questions to give the Dentist and idea of your Dental needs?

When was your last dental check up?

1. DO YOU CURRENTLY

Yes No

Grind your teeth?

 

Wake up with face/jaw ache?

 

Find your jaws click when you open wide?

 

2. ARE YOU CONCERNED ABOUT

Yes No

Your teeth when you smile?

 

The colour of your teeth?

 

The silver fillings in your mouth?

 

The old crowns that do not match?

 

Any old worn denture that looks/feels false?

 

3. ARE YOUR GUMS

Yes No

Red and swollen?

 

Do they bleed on brushing?

 

Do you suffer from bad breath?

 

And sensitive teeth?

 

4. DO YOU PLAY CONTACT SPORTS?

Yes No

Do you wear a sports guard?

 

5. WOULD YOU LIKE MORE INFORMATION ON

Yes No

Tooth whitening?

 

Cosmetic dentistry?

 

Hygiene and periodontal treatment?

 

Root canal treatment?

 

Implants?

 

Facial rejuvenation (wrinkles and fine lines)?

 

Oral surgery?

 

Any other comments? .....