

# 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. All information will be kept strictly confidential by the people caring for you who all adhere to our Data Protection Policy.

Title  First name  Surname

Sex  Male  Female Date of birth  Day  Month  Year

Address

Postcode

Telephone home  Work  Mobile

Occupation  Email

Doctor's name and Practice

I do/do not give consent to receive courtesy text/e-mail/phone reminders

**1. ARE YOU CURRENTLY** Yes No

- Pregnant?  Yes  No
- Receiving treatment from a doctor, hospital or clinic?  Yes  No
- Taking prescribed medicines (eg tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?  Yes  No
- Carrying a medical warning card?  Yes  No

**2. DO YOU SUFFER FROM** Yes No

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

**3. DID YOU, AS A CHILD OR SINCE, HAVE** Yes No

- Rheumatic fever or chorea?  Yes  No
- Liver disease (eg jaundice, hepatitis), or kidney disease?  Yes  No
- Any other serious illness?  Yes  No

**4. DID YOU, AS A CHILD OR SINCE, HAVE** Yes No

- Blood refused by the Blood Transfusion Service?  Yes  No
- A bad reaction to general or local anaesthetic?  Yes  No
- A joint replacement or other implant?  Yes  No
- Treatment that required you to be in hospital?  Yes  No
- Heart Surgery? / Brain Surgery?  Yes  No
- Growth hormone treatment before the mid-1980s?  Yes  No
- A close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease  Yes  No

**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)?  Yes  No  In past  times per day
- Have you ever chewed tobacco, pan, or use gutkha or supari  Yes  No  In past

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

I do/do not give permission for my details to be sent on if I am referred on to another dental service.

If you have answered yes to any of the above please give details

Please explain any disabilities or if you require any further assistance here

COMPLETED BY Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Self / Parent / Guardian Date: \_\_\_\_\_

Next of Kin Name: \_\_\_\_\_ Contact Number(s): \_\_\_\_\_

Staff Signature: \_\_\_\_\_ (Before Scanning) Date: \_\_\_\_\_

# Consent for communication

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Here at the Abbeymead we take your privacy seriously.

Your support matters so we would like to use your details to keep in touch about things that may matter to you. To do this, we need to ask you for your consent before sending this type of promotional message.

We have not and do not pass your details on to third parties for unsolicited marketing purposes.

**Please be aware that other message you may currently receive from us, such as recalls and appointment reminders, are not considered promotional activity and are therefore excluded from being covered by this request for consent.**

We hope that you will appreciate the benefit of receiving these promotional messages, but should you wish to withhold consent then please simply decline to sign this form. If you do provide consent, you may subsequently withdraw your consent at any time.

You can contact me by:

- SMS Mobile       Email       Letter

Name: .....

On behalf of, (patient name): .....

Signed: ..... Date: .....

**Your support phone number: 01932 571200**  
**Your support email address: enquiries@abbeymeaddental.co.uk**

Please see our Privacy Notice on our website for more information on how we look after your personal information. “We” means DR K T TANNA, Abbeymead Dental Centre.