EASTGATEDENTAL
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DENTAL CLINIC

CONFIDENTIAL MEDICAL HISTORY FORM

To provide the best and safest treatment, your dentist needs to know of any problems which may affect your treatment.

Surname: Dr/Mr/Mrs/Miss/Ms ..... Sex ☐ M ☐ F

Forename(s) .....

Address .....

..... Postcode .....

Telephone number ..... Work .....

Mobile ..... Email .....

Date of Birth ..... Occupation .....

When did you last receive dental treatment? .....

Your doctor's name and address .....

.....

Questions	Yes	No	If Yes, please give details
Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Are you taking any medication, tablets, drugs or injections, using any ointments or inhailers?			
Have you taken steroids in the last two years?			
Are you allergic to penicillin?			
Are you allergic to any medication, food or materials?			
Are you pregnant or a nursing mother?			
Are you HIV positive?			
Have you had rheumatic fever or cholera?			
Have you had jaundice, liver or kidney disease or hepatitis?			

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Questions	Yes	No	If Yes, please give details
Did you as a child or since have brain surgery, growth hormone treatment before the mid 1980's or have a close relative with Creutzfeldt Jakob disease?			
Have you ever been told that you have a heart murmur, heart problem, angina or high blood pressure?			
Have you ever had your blood refused by the blood transfusion service?			
Have you ever had a bad reaction to local or general anaesthetic?			
Have you had any joint replacements or implants?			
Have you been hospitalised for any reason?			
Do you have arthritis?			
Do you have a pacemaker or have you had heart surgery?			
Do you suffer from hay fever, eczema or any other allergy?			
Do you suffer from bronchitis, asthma or any other chest conditions?			
Do you have fainting attacks, giddiness, blackouts or epilepsy?			
Do you have diabetes or does anyone in the family?			
Do you bruise easily or suffer persistent bleeding following a tooth extraction or injury or does anyone in the family?			
Do you carry a warning card?			
Do you think there are any other aspects concerning your health that the dentist should know about?			
On average, how much of the following do you consume per day?	Cigarettes		Alcoholic drink .....

Signed ..... **Date** .....