

CONFIDENTIAL MEDICAL HISTORY

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

Surname

Forename(s)

Date of Birth

| | Yes | No | If yes, please give details |
|---|-----|----|-----------------------------|
| Are you attending or receiving treatment from a doctor, hospital, clinic or specialist? | | | |
| Are you taking any medicines, drugs, tablets, or injections or using any creams, ointments or inhalers? | | | |
| Are you taking or have taken steroids in the last 2 years? | | | |
| Are you allergic to penicillin? | | | |
| Are you allergic to any medicines, foods or materials? | | | |
| Are you pregnant or a nursing mother? | | | |
| Are you HIV positive? | | | |
| Have you had Rheumatic Fever or Chorea? | | | |
| Have you had jaundice, liver or kidney disease or hepatitis? | | | |
| Do 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 a local or general anaesthetic? | | | |
| Have you had a joint replacement or implant? | | | |
| 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 bronchitis, asthma or other chest condition? | | | |
| Do you suffer from hay fever, eczema or any other allergy? | | | |
| Do you have fainting attacks, giddiness, blackouts or epilepsy? | | | |
| Do you or anyone in you family have diabetes? | | | |
| Do you bruise easily or suffer persistent bleeding following a tooth extraction or injury? | | | |
| Do you carry a warning card? | | | |
| Are there any other aspects, concerning your health, that your dentist should know about? | | | |

Signed

(Patient/Parent/Guardian.)

Date

Amendments Signed

Signed

Signed

Date

Date

Date

Signed

Signed

Signed

Date

Date

Date