

CONFIDENTIAL MEDICAL HISTORY

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

NAME: ADDRESS: TEL NO. HOME: TEL NO. WORK: TEL NO. MOB: YOUR DOCTORS NAME AND ADDRESS:	DATE OF BIRTH:
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- | | Yes | No |
|---|--------------------------|--------------------------|
| • Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have you had any operations or serious illnesses? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Are you attending a doctor, hospital, clinic or specialist? | <input type="checkbox"/> | <input type="checkbox"/> |

REVIEW

	Yes	No	Further Details
Do you have or have you had any problems with your: Chest e.g. asthma, bronchitis, shortness of breath or a Consistent cough	<input type="checkbox"/>	<input type="checkbox"/>	-----
Heart e.g. angina, 'murmur', rheumatic fever a replacement valve or pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	-----
Blood Pressure? (high or low?)	<input type="checkbox"/>	<input type="checkbox"/>	-----
Circulation and Blood e.g. anaemia or prolonged bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	-----
Stomach and intestine e.g. ulcers, gastric reflux, colitis, jaundice, or cirrhosis of liver?	<input type="checkbox"/>	<input type="checkbox"/>	-----
Kidneys e.g. chronic infections?	<input type="checkbox"/>	<input type="checkbox"/>	-----
Nervous system e.g. epilepsy, Parkinson's disease, multiple sclerosis or a stroke?	<input type="checkbox"/>	<input type="checkbox"/>	-----
Hormonal system e.g. diabetes or thyroid?	<input type="checkbox"/>	<input type="checkbox"/>	-----
Joints and bones e.g. arthritis, or replacement joints?	<input type="checkbox"/>	<input type="checkbox"/>	-----
Skin & Mucous Membranes e.g. eczema, psoriasis or ulcers?	<input type="checkbox"/>	<input type="checkbox"/>	-----
Allergies and Sensitivities e.g. allergy to penicillin or any other drugs or to rubber, foods or material?	<input type="checkbox"/>	<input type="checkbox"/>	-----
PLEASE STATE IF NONE PRESENT			
Are you taking any medications, or drugs which are prescribed, bought over the counter or recreational? e.g. steroids, warfarin, chemotherapy). If so please list over the page.	<input type="checkbox"/>	<input type="checkbox"/>	

PTO

MEDICATION/DRUGS (including dose and frequency)	DOSE	FREQUENCY	DATE STARTED	DATE STOPPED

- | | Yes | No | Further Details |
|---|--------------------------|--------------------------|-----------------|
| • Have you ever had sedation or a general anaesthetic? | <input type="checkbox"/> | <input type="checkbox"/> | |
| • Do you have any history of illnesses e.g. sickle cell anaemia, thalassaemia, diabetes, heart disease? | <input type="checkbox"/> | <input type="checkbox"/> | |
| • Could you possibly have contracted an infection such as hepatitis, HIV, TB or CJD? | <input type="checkbox"/> | <input type="checkbox"/> | |
| • Could you be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> | |

SOCIAL HISTORY

- Occupation -----
- Do you currently smoke/ use any form of Tobacco. Please indicate type used Cigarettes Cigar Pipe Roll up Chewing
- If you smoke cigarettes – how many do you smoke a day? -----
Are they tipped untipped
- If roll ups, how many grams/ounces do you smoke a week? -----
- How many years have you been smoking/chewing for? -----
- If you have smoked in the past, but now given up, in which year did you give up? -----
- How much alcohol (units) do you usually drink per week? -----

DENTAL HISTORY

- When did you last receive dental treatment? -----
- Are you normally a regular attendee? -----
- **Are there any aspects of the appearance of your teeth you would like to improve and discuss with the dentist?** -----

Reviewed, signed and updated by patient						
Name						
Date						