

Confidential medical history

We ask you for information about your general health to help us treat you safely. Please complete the form and sign it where indicated. All information will be kept confidential by the people caring for you.

Name: _____

Title: _____ Date Of Birth: _____

Sex: Male / Female

Doctors Name: _____

Doctors Address: _____

Are you currently:	Yes	No	Give details
Attending or receiving treatment from a doctor, hospital or specialist?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Taking any medicines from your doctor? (Tablets, Ointments, injections or inhalers, including Contraceptives and hormone replacement therapy?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Allergic to any medicines or substances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Have you:	Yes	No	Give details
Had rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Ever been told you had a heart problem or heart attack, angina or blood pressure issues?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Had any blood tests or inoculations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Had your blood refused by the blood transfusion service?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Had a bad reaction to local or general anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Had a joint replaced?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Been hospitalised?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Do you:	Yes	No	Give details
Have arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Have a pacemaker. Or had any form of heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Suffer from hayfever, eczema or other allergy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Suffer from bronchitis, asthma or other chest condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Have fainting attacks, giddiness, blackouts or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Have diabetes or does anyone in your family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Bruise easily following a tooth extraction, injury or surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Carry a medical warning card?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Ever get cold sores?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Had jaundice, liver, kidney disease or hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Smoking	Yes	No	In past
Do you smoke any tobacco products now or in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Drinking

How many units of alcohol do you drink per week? Units per week

Please give any other details which your dentist might need to know about

Completed by (please tick) Self Parent Guardian

Signature Date

New Town Dental Care

