

Confidential Medical History Form



We ask you for information about your general health to help us treat you safely. Please complete your contact details below, answer all the health questions and then sign the form. Information supplied to Birchington Dental Care will be kept strictly confidential.

Title:	Surname:	First name:
Date of birth: ____ / ____ / ____		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:		Postcode:
		Occupation:
Telephone number (home):		Mobile number:

In the event of an emergency, please contact

Name:
Telephone number:
Relationship to you:

Best interest contact

Name:
Telephone number:
Relationship to you:

Doctor's details

Doctor's name:	Telephone number:
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Address:	Postcode:
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Do you have: Hearing loss? Sight loss? Mobility problems?

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 small glass of wine) units per week

Do you smoke tobacco products? Yes How many daily: No In the past

Do you chew tobacco, pan or use gutkha? Yes No In the past

Are you currently yes no give details

Receiving treatment from a doctor, hospital or clinic?	<input type="checkbox"/>	<input type="checkbox"/>
Taking any prescribed medicines? (including tablets, inhalers, injections, contraceptives and ointments) Please list in detail or additional sheet if required.	<input type="checkbox"/>	<input type="checkbox"/>
Taking any self prescribed medicines/drugs? (including pain killers or recreational drugs)	<input type="checkbox"/>	<input type="checkbox"/>
Carry a medical warning card or bracelet?	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant or possibly pregnant?	<input type="checkbox"/>	<input type="checkbox"/> Date baby due:

DOB: _____

First Name: _____

Surname: _____

FOR OFFICE
USE ONLY

Have you ever had**yes****no****give details**

Allergies to drugs (eg penicillin, chlorhexidine), plasters, latex or food?	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis/ Asthma/TB/ COPD or other chest condition?	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy or other neurological disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
Heart problems/ Angina/ High or Low blood pressure/ Stroke /Endocarditis/Valve disease or Heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
Bone or joint disease? (eg osteo or inflammatory arthritis, osteoporosis etc)	<input type="checkbox"/>	<input type="checkbox"/>	
Persistent bleeding or bruising after injury, tooth extraction & surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you taking blood anticlotting drugs eg Warfarin or Prothrombin Inhibitor?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you taking bisphosphonate medication (eg Alendronic Acid)?	<input type="checkbox"/>	<input type="checkbox"/>	
Liver disease?	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney or urinary tract disease?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have/have you had infections Hepatitis B, Hepatitis C or HIV?	<input type="checkbox"/>	<input type="checkbox"/>	
Mental health problems? (e.g. Alzheimer's Disease, Dementia, Depression, Schizophrenia or Bipolar disorder)	<input type="checkbox"/>	<input type="checkbox"/>	
Learning disability?	<input type="checkbox"/>	<input type="checkbox"/>	
Drug or alcohol addiction?	<input type="checkbox"/>	<input type="checkbox"/>	
An operation under general anaesthetic in hospital?	<input type="checkbox"/>	<input type="checkbox"/>	
Other treatment that required you to be in hospital?	<input type="checkbox"/>	<input type="checkbox"/>	
Any other disabilities or conditions not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	
A TEP or Resuscitation Decision Record in place	<input type="checkbox"/>	<input type="checkbox"/>	

Patient/Carer/Parent Signature: _____		Date: _____	
Dentist Signature: _____		Date: _____	
Completed by (please tick)	self <input type="checkbox"/>	parent <input type="checkbox"/>	guardian <input type="checkbox"/>

