CONFIDENTIAL MEDICAL HISTORY FORM

SOUTHWOOD DENTAL CENTRE

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

Surname: ..... Forenames: .....

Date of Birth: ..... …… Sex: Male ☐ Female ☐ Ethnicity: ……

Address: ..... Post Code: .....

Tel Nos. Home: ..... Work: ..... Mobile: .....

Email address: …… How long since last received Dental Treatment: Yrs ☐ Mths ☐

Occupation: …… Your Doctor's Name & Address: ……

	YES	NO	DETAILS
ARE YOU: 1. Attending or receiving treatment from a doctor, hospital , clinic or specialist?			
2. Taking any medicines from your doctor? (Tablets, creams, ointments, injections, other) Please list all medication			
3. Taking or have you taken steroids in the last two years?			
4. An expectant mother?			
HAVE YOU: 1. Had rheumatic fever or chorea (St. Vitus Dance)?			
2. Had jaundice, liver or kidney disease?			
3. Ever been told you have a heart murmur or heart problem, angina, blood pressure problems, heart attack or had a pacemaker or heart surgery?			
4. Had growth hormone replacement treatment before the mid 1980s?			
5. Ever had your blood refused by the Blood Transfusion service?			
6. Had a bad reaction to a general or local anaesthetic?			
7. Had a joint replacement or other implant?			
8. Been hospitalised? If YES what for and when?			
DO YOU: 1. Have arthritis?			
2. Suffer from any infectious diseases (including HIV or hepatitis)?			
3. Take any self-prescribed medicines, e.g. aspirin?			
4. Suffer from bronchitis, asthma or other chest condition?			
5. Have fainting attacks, giddiness, blackouts or epilepsy?			
6. Have diabetes or does anyone in your family?			
7. Bruise easily or - following a tooth extraction, surgery or injury - have you or your family bled so as to cause you to be worried?			
8. Carry a warning card?			
9. Ever get cold sores?			
10. Suffer from hay fever, eczema or any allergy to medicines, foods or materials?			
11. Smoke? If so, how many a day.			
12. Drink alcohol? If so, how many units per week.			

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

Please note: This questionnaire will form part of your confidential clinical records

Completed by: Patient/Parent/Guardian Signature: ..... Date: .....