Confidential Medical History Form

We ask you for information about your general health to help us treat you safely.

Please write your contact details below, answer the health questions and then sign the form on the back page. We will use this form at later visits to discuss any change in your general health. All information will be kept strictly confidential by the people caring for you.

Title:

Last name:

First name:

Date of birth:

Sex: Male ☐ Female ☐

Child patients:

School attended:

Address:

Postcode:

Telephone number (home):

Mobile number:

Email:

Occupation:

How did you hear about the practice?

In the event of an emergency, please contact

Name:

Telephone number:

Relationship to you:

Doctor's details

Doctor's name:

Telephone number:

Address:

Postcode:

NHS number:

Please tick all that apply

Habits

Smoke (per day)		High sugar / frequency	
Chew tobacco (per day)		Lots of fizzy / acidic drinks	
Alcohol (units per week)		Recreational drugs	

Example 1 unit = one single measure of whisky (ABV 40%), or a third of a pint of beer (ABV 5-6%) or half a (175ml) glass of red wine (ABV 12%)

Details

Heart

Rheumatic fever		Heart murmur	
High blood pressure		Angina	
Heart surgery		Thrombosis	
Pacemaker fitted		Other heart conditions	

Details

Blood

Hepatitis		Anaemia	
H.I.V.		Sickle cell	
Abnormal blood test		Haemophilia	
Blood refused by transfusion service		Other blood conditions	

Details

Allergies

Penicillin		Latex allergy	
Hay fever		Medicines	
Anti Tetanus serum		Plants	
Eczema		Foods	
General anaesthetic		Aspirin	
Local anaesthetic		Other allergy conditions	

Details

Warnings

Pregnant or possibly pregnant		Do not recline	
Antibiotic cover required		Steroids within 2 years	
Bruising or persistant bleeding		Warning card	
Currently under treatment		Treatment requiring hospitalisation	
Anything dentist should know			

Details

Chest

Bronchitis		Emphysema	
Cystic fibrosis		Pneumonia	
Pleurisy		Chest surgery	
Asthmatic		Other chest conditions	

Details

Medication

Other

Liver disease		Kidney disease	
Diabetes		Epilepsy	
Acid reflux or eating disorder		Hiatus hernia	
Bone or joint disease		Artificial joint	
Fainting attacks or blackouts		Giddiness	
Past serious or infectious disease		Cancer	

Details

Please give any other details which your dentist might need to know about such as chemotherapy radiotherapy, self-prescribed medicines (eg aspirin) or any disabilities you may have.

Completed by (please tick) self ☐ parent ☐ guardian ☐

Patient signature _____ Date _____
or
Print name _____

Dentist signature _____ Date _____

I consent to my appointment information (with regard only to appointment reminders, rescheduling or cancellation) being shared with the following people (eg. family member, partner etc):

Name _____ Relationship _____

Name _____ Relationship _____

No information other than this will be shared with any 3rd parties without patient consent.

Medical history update

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

Date	Any changes?	List changes below	Patient signature