Confidential Medical History Form

Clinician: **Patient ID number: .....**

Patient's Details:

Title:.....

First Name: .....

Surname:.....

D.O.B: .....

Patient's address:.....

.....

.....

Postcode:.....

Home Tel:.....

Work Tel:.. .....

Mobile Tel:.....

Email: .....

NHS Number: .....

Doctor's Name: .....

Practice: .....

Dentist's Name: .....

Practice: .....

Are you currently:			**If yes, then please give details**
Pregnant?	☐ Yes	☐ No	.....
Receiving treatment from a doctor, hospital or clinician?	☐ Yes	☐ No	.....
Taking any medication?	☐ Yes	☐ No	.....
Carrying a medical warning card?	☐ Yes	☐ No	.....
A smoker?	☐ Yes	☐ No	.....
An alcohol drinker?	☐ Yes	☐ No	Number of Units per week = ...

Do you have, or have you ever suffered from:			**If yes, then please give details**
Diabetes?	☐ Yes	☐ No	.....
Liver or Kidney problems?	☐ Yes	☐ No	.....
Fainting, Blackouts, Epilepsy?	☐ Yes	☐ No	.....
Cancer?	☐ Yes	☐ No	.....
Eczema?	☐ Yes	☐ No	.....
Asthma?	☐ Yes	☐ No	.....
Reaction to local/general anaesthetic?	☐ Yes	☐ No	.....
Blood borne infectious diseases (eg. Hepatitis/HIV)?	☐ Yes	☐ No	.....
Anaemia /Sickle Cell?	☐ Yes	☐ No	.....
Heart problems, murmurs, high blood pressure?	☐ Yes	☐ No	.....
Growth Hormone treatment before 1980s?	☐ Yes	☐ No	.....
Cold sores?	☐ Yes	☐ No	.....

In the past 2 years have you:			**If yes, then please give details**
Undergone any operations?	☐ Yes	☐ No	.....
Been treated with corticosteroids or hydrocortisone?	☐ Yes	☐ No	.....
Used drugs intravenously?	☐ Yes	☐ No	.....

Clinician: **Patient ID number: ……**

Do you have any allergies to medicines or substances?			**If yes, then please give details**
Penicillin?	☐ Yes	☐ No	……
Latex?	☐ Yes	☐ No	……
Other allergy? (please state)	☐ Yes	☐ No	……
Do you, or have you ever suffered from bruising or persistent bleeding following tooth extraction or Surgery?	☐ Yes	☐ No	……
Are you taking Bisphosphonates as part of HRT or For any other reasons?	☐ Yes	☐ No	……

N.B.: As a part of your initial consultation, and occasionally during treatment, you may require one or more dental radiographs to be taken. These have a very low risk and are of a lower dose than many medical films. However, please be advised that, as with all radiographs, they do carry some potential risk of exacerbating future disease in particular there is a theoretical risk that taking any radiographs, including dental radiographs, may cause tissue dysplasia. This risk is minimal, however we are required to make you aware.

Please tick here to confirm you understand this and agree to radiographs being taken where deemed appropriate by your clinician**.** ☐

If you have learning difficulties, any special requirements or any other condition which may affect your treatment please give details:

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Please note some of our dental chairs have weight limits of 21 stone (127kg) if you feel that this is an issue, please alert your dentist in confidence.

Ethnic Origin:

☐ White British	☐ White Irish	☐ Other White Background
☐ White and Black Caribbean	☐ White and Black African	☐ White Asian
☐ Indian	☐ Bangladeshi	☐ Pakistani
☐ Chinese	☐ Black Caribbean	☐ Other Ethnic Background
☐ Other Asian Background	☐ Black African	☐ Other Black background

This practice complies with the General Data Protection Regulations 2018 and we operate a data protection code of practice for our patients, a copy of which is in our practice information folder at Reception. Please tick below to agree to specific usage of your information: **(please tick all that apply)**

Clinical notes, including xrays: Dental colleagues as part of treatment ☐ Case study ☐ Teaching ☐

Contact information: Dental colleagues as part of treatment ☐ Practice information ☐ Practice promotions ☐

Contact methods: Telephone ☐ SMS ☐ Email ☐ Post ☐ N.B. Appointment reminders can only be sent via SMS

Medical History Form completed by (please tick): ☐ Self ☐ Parent ☐ Guardian

Sign: …… Date: ……

Print: …… Date: ……