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: ……

Doctor's Name: ……

Practice: ……

Your preferred method of appointment reminder:

☐ SMS ☐ Email

☐ Letter ☐ Landline

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

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

……

……

Are you currently:			**If yes, then please give details**
Pregnant?	☐ Yes	☐ No	……
Receiving treatment from a doctor, hospital or clinician?	☐ Yes	☐ No	……
Carrying a medical warning card?	☐ Yes	☐ No	……
A smoker?	☐ Yes	☐ No	……

Please give details of any medication you are taking:

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……

……

Clinician: **Patient ID number: ……**

Have you ever:			**If yes, then please give details**
Undergone any operations?	☐ Yes	☐ No	……
Been treated with corticosteroids or hydrocortisone?	☐ Yes	☐ No	……
Used drugs intravenously?	☐ Yes	☐ No	……
Had a pacemaker?	☐ Yes	☐ No	……
Had heart surgery including a replacement valve ?	☐ Yes	☐ No	……

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	……

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	……

Do you agree to have your photographic records taken and used for clinical purposes only? ☐ Yes ☐ No

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

Sign: …… Date: ……

Print: …… Date: ……

Apex dental group

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P.T.O.