CONFIDENTIAL MEDICAL HISTORY FORM

TITLE NAME

DATE OF BIRTH SEX:MALE/FEMALE

ADDRESS

POST CODE

TEL NO: HOME WORK MOBILE

E MAIL HOW LONG SINCE LAST RECEIVED DENTAL TREATMENT

YOUR DOCTOR'S NAME AND ADDRESS

EXPECTANT MOTHER:YES/NO

HOW DID YOU HEAR ABOUT US?

ARE YOU:	YES	NO	DETAILS
1.Attending or receiving treatment from a doctor,hospital,clinic or specialist?			
2.Taking any medicines from your doctor?(tablets,creams,injections,other)			
3.Taking or have you taken steroids in the last two years?			
4.Allergic to any medicines,foods or materials?			
HAVE YOU: 1.Had rheumatic fever or been told you have a heart murmur?			
2.Had jaundice,liver,kidney disease or hepatitis?			
3.Ever had a heart attack or heart problem, infective endocarditis, heart valve replaced or any other form of heart surgery including pacemaker?			
4.Had any blood tests,inoculations etc?			
5.Ever had your blood refused by the Blood Transfusion Service?			
6.Had a bad reaction to a general or local anaesthetic?			
7.Ever been diagnosed or suspected as having V CJD or being HIV positive?			
8.Been hospitalised?if "YES" what for and when?			
DO YOU: 1.Have arthritis?			
2.Suffer from hayfever,eczema or any other allergy?			
3.Suffer from bronchitis,asthma or other chest conditions?			
4.Have fainting attacks,giddiness,blackouts or epilepsy?			
5.Have diabetes or does anyone in your family?			
6.Bruise easily. Following a tooth extraction,surgery or injury,have you or your family bled so as to cause you to be worried?			
7.Carry a warning card?			
8.Smoke and if yes how many a day?			
9.Drink alcohol and if yes how many units a week?			
Are there any other aspects concerning your health that you think the dentist should know about?			

Completed by:Self/Parent/Guardian. Signature.....

Date.....

By signing this form you are agreeing to us being able to contact you by letter, telephone or e mail unless this box is crossed out. This will only be for matters arising from the practice ie cancellations etc

To obtain the best and safest treatment,we need to know of any problems which may affect your treatment.

PLEASE TELL US IMMEDIATELY IF YOUR MEDICAL HISTORY CHANGES! IT WILL HELP AVOID ANY PROBLEMS.

DENPLAN EXCEL Quality Assured

Denplan At the heart of dental care