Coppertop Dental Surgery

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CONFIDENTIAL MEDICAL HISTORY FORM

Like all dentists, we ask patients for information about their general health to help us treat them safely. Please write your contact details below, answer the health questions inside and then sign the form on the back page. We will show you the form at later visits so that you can tell us whether there has been any change in your general health. All information will be kept strictly confidential by the people caring for you.

Surname

First name/s

Title

Sex ☐ male ☐ female

Date of birth ☐ day ☐ month ☐ year

Address

postcode

Telephone home

work

Occupation

Doctor's name and address

Doctor's Telephone

ARE YOU CURRENTLY

	Yes	No	Give details
Pregnant?	☐	☐	
Receiving treatment from a doctor, hospital or clinic?	☐	☐	
Taking any prescribed medicines (eg tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?	☐	☐	
Carrying a medical warning card?	☐	☐	

DO YOU SUFFER FROM

	Yes	No	Give details
Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?	☐	☐	
Hay fever or eczema?	☐	☐	
Bronchitis, asthma or other chest condition?	☐	☐	
Fainting attacks, giddiness, blackouts, epilepsy?	☐	☐	
Heart problems, angina, blood pressure problems or stroke?	☐	☐	
Diabetes (or does anyone in your family)?	☐	☐	
Arthritis?	☐	☐	
Bruising or persistant bleeding following injury, tooth extraction or surgery?	☐	☐	
Any infectious diseases (including HIV and hepatitis)?	☐	☐	

DID YOU, AS A CHILD OR SINCE, HAVE

	Yes	No	Give details
Rheumatic fever or chorea?	☐	☐	
Liver disease (eg jaundice, hepatitis) or kidney disease?	☐	☐	
Any other serious illness?	☐	☐	

DID YOU, AS A CHILD OR SINCE, HAVE

	Yes	No	Give details
Blood refused by the Blood Transfusion Service?	☐	☐	
A bad reaction to general or local anaesthetic?	☐	☐	
A joint replacement or other implant?	☐	☐	
Treatment that required you to be in hospital?	☐	☐	
Heart surgery?	☐	☐	
Brain surgery?	☐	☐	
Growth hormone treatment before the mid1980's?	☐	☐	
A close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob disease?	☐	☐	

DRINKING

How many units of alcohol do you drink per week?
(A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitiff.) ☐ units per week

SMOKING AND CHEWING

	Yes	No	In Past		
Do you smoke any tobacco products now (or did you in the past)?	☐	☐	☐	☐	times per day
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)?	☐	☐	☐	☐	times per day

PLEASE GIVE ANY OTHER DETAILS WHICH YOUR DENTIST MIGHT NEED TO KNOW ABOUT, SUCH AS SELF-PRESCRIBED MEDICINES (EG ASPIRIN)

In this practice we treat many nervous or apprehensive patients with the help of inhalation sedation (Relative Analgesia). Would you prefer to have your treatment carried out by this method? Yes ☐ No ☐ Perhaps ☐

COMPLETED BY (PLEASE TICK)

☐ Self ☐ Parent ☐ Guardian

Signature _____ Date _____

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	No change?	List any changes below	Patient's initials