Southgate Smiles dental care

CONFIDENTIAL MEDICAL HISTORY SHEET

Like all dentists, we ask patients for information about their general health to help us to treat them safely. Please write your contact details below, answer the health questions below and then sign the Form. 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

Surname:_____ Title: _____

Forenames _____

Sex: Male/Female _____ Date of Birth _____

Address:: _____

_____ Post Code _____

Telephone: Home: _____ Work:_____ Occupation _____

Date of last dental treatment _____ Doctor's Name: _____

Address: _____ Tel: _____

Please Tick Boxes

ARE YOU CURRENTLY	**YES**	**NO**
1. Pregnant?	☐	☐
2. Receiving treatment from a doctor, hospital or clinic?	☐	☐
3. Taking any prescribed medicines (e.g. Tablets, ointments, injections or inhalers, including Contraceptives and hormone replacement Therapy?	☐	☐
4. Carrying a medical warning card?	☐	☐

DO YOU SUFFER FROM	**YES**	**NO**
5. Allergies to any medicines (e.g. Penicillin), Substances (e.g. Latex/rubber) or foods?	☐	☐
6. Hay fever or eczema?	☐	☐
7. Bronchitis, asthama or other chest condition?	☐	☐
8. Fainting attacks, giddiness, blackouts, epilepsy?	☐	☐
9. Heart problems, angina, blood pressure problems, or stroke?	☐	☐
10. Diabetes (or does anyone in your family)?	☐	☐
11. Arthritis?	☐	☐
12. Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐	☐
13. Any infectious diseases (including HIV and hepatitis)?	☐	☐

DID YOU, AS A CHILD OR SINCE, HAVE	**YES**	**NO**
14. Rheumatic fever or chorea?	☐	☐
15. Liver disease (e.g. Jaundice, hepatitis) or Kidney disease?	☐	☐

Please Tick Boxes

DID YOU, AS A CHILD OR SINCE, HAVE	**YES**	**NO**
16. Any other serious disorders?	☐	☐
17. A bad reaction to general or local anaesthetic?	☐	☐
18. A joint replacement or other implant?	☐	☐
19. Treatment that required you to be in the Hospital?	☐	☐
20. Heart surgery?	☐	☐
21. Brain surgery?	☐	☐
22. Growth hormone treatment before the mid-1980s?	☐	☐
23. A close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease?	☐	☐

DRINKING	**YES**	**NO**	**UNITS PER WEEK**
25. 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/aperitif).*			*Units per week*

SMOKING AND CHEWING	**YES**	**NO**	**IN PAST**	**QUANTITY**
26. Do you smoke any tobacco products now (or did you in the past)? How many times per day?				*Units per day*
27. Do you chew tobacco, pan, use gutkha or Supari now (or did you in the past)? How many Times per day?				*Units per day*

PLEASE GIVE ANY OTHER DETAILS WHICH YOUR DENTIST MIGHT NEED TO KNOW ABOUT SUCH SELF-PRESCRIBED MEDICINES (E.G. ASPIRIN)._____

FORM COMPLETED BY: (Please tick) ☐ Self ☐ Parent ☐ Guardian Signature:_____

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	CHANGES	PATIENT'S INITIALS