



Confidential Medical History Form

To obtain the best and safest treatment your dentist needs to know of any problems which may affect your treatment. Please answer all questions and give details if the 'yes' box is ticked.

Mr/Mrs/Miss/Other	First Name	Surname	Sex M/F	Date of birth
Home address			Postcode	Home telephone
Work address			Postcode	Work telephone
Occupation	Mobile telephone		Would you prefer to be contacted by: Post <input type="checkbox"/> Email <input type="checkbox"/>	
Are you an expectant mother? Yes <input type="checkbox"/> No <input type="checkbox"/>	Medical Practitioner		Email address	
Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Please give details where possible	
Allergic to any medicine, food or material?	<input type="checkbox"/>	<input type="checkbox"/>		
Taking any medicine, tablets, creams, ointments or injections?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you had Rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you had Jaundice, Hepatitis, liver or kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you got a heart condition, Angina or abnormal blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you got a pacemaker or have had heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you got Bronchitis, Asthma or other chest condition?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you got Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you got Hay fever, Eczema or any other allergy?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you had fainting attacks, giddiness, blackouts or Epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you got Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	Type I <input type="checkbox"/>	Type II <input type="checkbox"/>
Have you got a medical warning card?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever had a bad reaction to local anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you got any specific dental concerns?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you floss your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	If 'yes', how often?	
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	If 'yes', how many?	
When did you last receive dental treatment?				
Are there any other aspects concerning your health you feel the dentist should know about?				
How did you hear about us? Internet <input type="checkbox"/> Yell.com <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Another patient <input type="checkbox"/> Walked past <input type="checkbox"/>				
Other <input type="checkbox"/> (please specify) _____				
1) Date _____ Signature _____		2) Date _____ Signature _____		3) Date _____ Signature _____