Title	Surname		First Names
Address			
Date of Birth		Male/Female	
Tel No Home:		Tel No Work	
Email Address:		Occupation:	
How long since last received dental treatment		Referral source	
Your Doctor's name and address			

Confidential Medical History Form

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. Are you taking Homeopathic Treatment or vitamins/ supplements?			
4. Taking or have taken steroids in the last two years?			
5. Allergic to any medicines, foods or materials including latex or chlorhexidine?			
6. Are you or do you think you may be pregnant?			
7. Are you in a high-risk category for any diseases?			
Have you :			
1. Had rheumatic fever or chorea (St Vitus Dance)?			
2. Had jaundice liver, kidney disease or hepatitis?			
3. Ever been told you have a heart murmur, heart problem, angina, high blood pressure, heart attack.			
4. Had any recent blood tests or any recent inoculations?			
5. Been hospitalised? If "YES" what for and when			
6. Ever had a bad reaction to a general or local anaesthetic?			
7. Ever had your blood refused by the Blood Transfusion Service?			
8. Had a joint replacement?			
9. Have you had any type of cosmetic surgery?			
Do you :			
1. Have arthritis?			
2. Have a pacemaker, or have you had any form of heart surgery?			
3. Suffer from hay fever, eczema or any other allergy?			
4. Suffer from bronchitis, asthma or other chest condition?			
5. Have fainting attacks, giddiness, blackouts or epilepsy?			
6. Have diabetes or does anyone in your family?			
7. Bruise easily or following a tooth extraction, surgery or injury or have you or a family member bled so as to cause you to be worried?			
8. Ever get cold sores?			
9. Do you smoke/ For How Long			
10. Drink alcohol-please state your average consumption per week			
11. Carry a warning card?			
12. Is there any other aspect concerning your health that you think the dentist should know?			

Signed:	Date:

Date	No Change (Tick)	List any changes below	Sign