# Confidential Medical History Form

**Personal Information:**

Full Name:

Address:

Date of Birth:

Home Phone:

Mobile Phone:

Email:

Occupation:

Do we have your consent to leave a message on your phone? Yes/No

**Next of kin:**
Name
Contact number

**Doctor:**
Name
Surgery
Contact number (if known)

**Medical History:**
Are you currently receiving treatment from a doctor, hospital or clinic? Yes/No

Are you taking any regular medication? Yes/No
Details (If you have a repeat prescription form please bring it with you to your appointment.

Are you pregnant or possibly pregnant? Yes/No

Do you carry a medical warning card? Yes/No

Do you have allergies to any medicines, substances or foods? Yes/No
Details:

Have you ever had a infectious diseases including HIV or Hepatitis? Yes/No

Have you ever had Heart surgery/Heart problems? Yes/No

Have you had your blood refused by the Blood Transfusion Service? Yes/No

Do you bleed or bruise excessively? Yes/No

Have you had a joint replacement or implant? Yes/No

Have you ever taken Bisphosphonates or steroids? Yes/No

Do you smoke? Yes/No

Do you drink alcohol? If yes, how much?

Have you ever suffered from any of the following?

| | |
|---|---|
| Rheumatic Fever/Chorea | Y/N |
| High Blood Pressure/Angina/Stroke | Y/N |
| Asthma | Y/N |
| Hayfever | Y/N |
| Eczema | Y/N |
| Arthritis | Y/N |
| Hepatitis A, B or C (please specify) | Y/N |
| Bronchitis or Chest Problems | Y/N |
| Severe Headaches | Y/N |
| Epilepsy/Black outs | Y/N |
| Anaemia | Y/N |
| Diabetes | Y/N |
| Kidney/Liver problems | Y/N |
| Cold Sores | Y/N |
| Reaction to an anaesthetic | Y/N |

**Dental history:**
Name of last dentist
Date of last dental visit

Are you nervous about seeking dental treatment? Yes/No

How did you hear about us?

**Is there anything you would like to discuss with the dentist or any concerns?**

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**Patient/Parent/Guardian Signature**

**Sign……Date……**

**Dentist**

**Sign……Date……**