CHESTFIELD DENTAL PRACTICE CONFIDENTIAL MEDICAL HISTORY FORM

Withholding medical information from us may put you at risk should something happen to you whilst you are in our care. In order to provide you with the most appropriate and safest treatment, your dentist needs to know about any current or previous medical conditions, since many of them can affect your dental treatment. Filling in a medical history form is standard practice. Please note that any information you give us is strictly confidential.

Title:____ First Name:_____ Surname:_____ Date of Birth:_____/_____/_____

Address:_____

Postcode:_____ Tel:_____ Mobile:_____ Email:_____

Doctor:_____ Surgery:_____ Tel:_____

Occupation:_____

Please tick YES or NO. If you answer YES to any questions on the form please give further details:

QUESTIONS	YES	NO	If YES give details
ARE YOU:			
Receiving treatment from a doctor, hospital, clinic or specialist?			
Taking any medicines prescribed by your doctor? (Tablets, creams, ointments, injections or inhalers including contraceptives or hormone replacement therapy.)			
Taking any self prescribed medicines?			
Allergic to penicillin or any other drug or substance?			
Likely to be pregnant? [I**f applicable]**			
Carrying any Medical Warning Card?			
20 stone/ 125kg or above in weight?			
Are you a Diabetic?			
HAVE YOU:			
Ever been told you have a heart problem, angina, high or low blood pressure or suffered a heart attack or stroke?			
Had Rheumatic Fever or Chorea (St Vitus Dance)?			
Ever had Liver Disease (e.g. Jaundice, Hepatitis) or Kidney Disease?			
Ever had any serious chest conditions e.g. Bronchitis, Asthma?			
Ever had any form of Cancer?			
Ever had any blood related diseases?			
Had any fainting attacks, giddiness, blackouts, Epilepsy?			
Ever had a reaction to Local or General Anaesthetic?			
Had a Heart Valve replacement?			
Had a joint or any other organ implant?			
Ever been hospitalised, and if YES, what for and when?			
DO YOU:			
Have Hay fever and/or Eczema?			
Have Arthritis?			
Have a Heart Pacemaker?			
Bruise easily or have persistent bleeding following injuries, tooth extraction or surgery?			
Have any infection diseases (including HIV or Hepatitis)?			
Take or have you taken Steroids?			
DID YOU as a child or since have**:**			
Growth hormone treatment before the mid 1980s?			
Any close relatives (parent, sibling, child, Grandparent) with C.J.D (Creutzfeldt Jakob Disease)?			
Heart surgery?			
Brain surgery?			
How many units of alcohol do you drink a week?			
Do you smoke or chew any tobacco products now or have you done in the past?			

Complete by: (Please tick) Self ☐ Parent ☐ Guardian ☐ Signature:…… Date:……/……/……