|  |  |  |  |
| --- | --- | --- | --- |
| **Confidential Medical History** |  | **PracticeName** |  |
| Forename:  |  |  |  | Address1 |  |
|  |  |  | Address2 |  |
| Surname: |  |  |  |  | Postcode |  |
| D.O.B.: |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **Habits** |  | Smokes (per day) |  | High sugar/frequency |  |  |
|  |  |  | Chews (per day) |  | Lots fizzy/acidic drinks |  |  |
|  |  |  | Alcohol (units per week) |  | Recreational drugs |  |  |
| **Heart** |  | Rheumatic Fever |  | Heart Murmur |  |  |  |  |
|  |  |  |  |  |
|  |  |  | High Blood Pressure |  | Angina |  |  |  |
|  |  |  | Heart Surgery |  | Thrombosis |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  | Pacemaker Fitted |  | Other Heart Condition |  |  |  |
|  |  | Hepatitis B |  |  |  |  |  |
| **Blood** |  |  | Anaemia |  |  |  |
|  |  |  | H.I.V. |  | Sickle Cell |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  | Abnormal Blood Test Result |  | Haemophilia |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  | Blood refused by transfusion svce. |  | Other Blood Condition |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **Allergies** |  | Penicillin |  | Latex Allergy |  |  |  |
|  |  |  | Hay Fever |  | Medicines |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  | Anti-Tetanus Serum |  | Plants |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  | Eczema |  | Foods |  |  |  |
|  |  |  | General Anaesthetic |  | Aspirin |  |  |  |
|  |  |  | Local Anaesthetic |  | Other Allergy |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **Warnings** |  | Pregnant or possibly pregnant |  | Do not recline |  |  |
|  |  |  | Antibiotic cover required |  | Steroids in last 2 years |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  | Bruising or persistent bleeding |  | Warning Card |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  | Currently under treatment |  | Required Hospitalisation |  |  |
|  |  |  | Anything dentist should know |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **Chest** |  | Bronchitis |  | Emphysema |  |  |  |  |
|  |  |  |  |  |
|  |  |  | Cystic Fibrosis |  | Pneumonia |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  | Pleurisy |  | Chest Surgery |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Medication** |  | Asthmatic |  | Other Chest Condition |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **Other** |  | Liver Disease |  | Kidney Disease |  |  |  |  |
|  |  |  |  |  |
|  |  |  | Diabetes / Family with Diabetes |  | Epilepsy |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  | Acid Reflux or Eating Disorder |  | Hiatus Hernia |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  | Bone or Joint Disease |  | Artificial joint |  |  |  |
|  |  |  | Fainting Attacks or Blackouts |  | Giddiness |  |  |  |  |
|  |  |  | Past serious or infectious disease |  | Cancer |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Doctor's Name: | Emergency Contact: |  |
| Practice Phone: | Contact Number: |  |
| Practice Name: | Relationship: |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| Signature: |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| (Patient, Parent, |  |  |  |  |  |  |  |  |
| Guardian or Carer) |  |  |  | Date:  |  |
|  |  |  |  |  |  |  |  |

