

**CONFIDENTIAL MEDICAL HISTORY FORM**

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Doctors Name & Address |  |
| Occupation |  |

Please complete this form so that we can provide you with safe and comfortable treatment. It is important to include all information requested. (please circle options)

How would you rate your general health?

Excellent Good Fair Poor

Please answer the following questions by ticking YES or NO

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| Has there been a recent change in your health? |  |  |
| Details: | | |
| Do you have any allergies? |  |  |
| Have you been in hospital in the last 2 years? |  |  |
| If so what for? | | |
| Have you consulted your doctor in the last 2 years? |  |  |
| If so what for? | | |
| **Do you, or have you ever had?** | | |
|  | YES | NO |
| Chest pains |  |  |
| Anaemia |  |  |
| Palpitations (abnormal heart beat) |  |  |
| Swollen ankles |  |  |
| Heart attack |  |  |
| High blood pressure |  |  |
| Stroke |  |  |
| Rheumatic Fever |  |  |
| Do you have sickle cell disease or trait |  |  |
| Bronchitis |  |  |
| Asthma |  |  |
| Do you have a cold/chest infection at the moment? |  |  |
| Do you cough regularly (eg in the morning)? |  |  |
| Do you smoke? |  |  |
| If so how many a day? | | |
| Hiatus hernia |  |  |
| Kidney or liver disease |  |  |
|  | YES | NO |
| Ulcers |  |  |
| Epilepsy |  |  |
| Diabetes |  |  |
| Fainting/dizzy spells |  |  |
| Thyroid problems |  |  |
| Arthritis |  |  |
| Do you have any other serious illness not listed above? |  |  |
| Have you ever had excessive bleeding requiring special treatment? |  |  |
| Could you be pregnant? |  |  |
| Are you at risk of infection with hepatitis or HIV? |  |  |
| Do you take recreational drugs? |  |  |
| How much alcohol do you drink a week?  ……………Units | | |
| Have you ever had a general anaesthetic? |  |  |
| If so: When? | | |
| Any problems |  |  |
| Have you ever had a sedation? |  |  |
| If so: When? | | |
| Any problems? |  |  |
| What type of sedation?  Tablet Gas and air Injection in arm/hand Other | | |
| Is there any family history of problems with anaesthetics or sedation? |  |  |
| If so, please give details: |  |  |
| Please list any tablets, creams or other medication you are taking (include all herbal and over the counter medicines): | | |

|  |  |
| --- | --- |
| Completed by (please circle) | Self Parent Guardian |
| Patient signature |  |
| Dentist signature |  |
| Date |  |