CONFIDENTIAL MEDICAL HISTORY FORM

01 PERSONAL DETAILS

Mr Mrs Miss Ms

First Name | Last Name

NHS Number | DOB

Full address

Post Code | Email:

Tel (Home) | (Mobile)

How would you prefer to hear from us? You can tick more than one box, but please note we no longer send appointment reminders via post:

Text/SMS Email

Phone Post

02 EMERGENCY CONTACT DETAILS

Full name | DOB

Contact Tel: | GP Surgery

03 MEDICAL HISTORY

	YES	NO		YES	NO
Anaemia			Heart Problems (e.g. Heart Attack)		
Arthritis			High/ Low Blood Pressure		
Artificial Joints/ Heart Valves			HIV/ AIDS		
Bleeding Problems			Kidney Problems		
Bone Problems (e.g. Osteoporosis)			Liver Problems (e.g. Hepatitis)		
Cancer			Mental Health Issues		
Chest Problems (e.g. Asthma/ COPD)			Organ Transplant		
Chemotherapy/ Radiotherapy			Rheumatic Fever		
Coldsores			Stomach Problems (e.g. Reflux, IBS)		
Diabetes			Stroke/ Mini Stroke		
Epilepsy/Seizures/Fits			Surgery/ Operations		

If you have ticked any of the above or if you feel anything else is medically relevant, then please provide further details in the space below:

If you take any medication, please list them all in the space below:

If you have any allergies, please list them all in the space below:

04 LIFESTYLE HISTORY

Do you smoke? Yes ☐ No ☐

If yes, what do you smoke? Cigarettes ☐ Roll-Ups ☐ E-Cigs ☐ Cigars ☐

How many do you smoke per day? How many years have you smoked for?

Do you drink alcohol? Yes ☐ No ☐

If yes, how many units on average per week do you drink?

(Pint = 2 Units, Bottle of Wine = 9 Units, Glass of Wine = 1 or 2 units, Can of beer/Lager/Cider = 2 Units, Single Spirit = 1 Unit, Alcopop = 1.5 Units)

Have you ever been dependant on drugs? Yes ☐ No ☐

If yes, please provide more detail

Oral Cancer Risk : High ☐ Medium ☐ Low ☐ (Dentist to complete)

05 FEMALES ONLY

Are you pregnant? Yes ☐ No ☐ If so, when is your baby due?

Are you breastfeeding? Yes ☐ No ☐

06 SIGNATURE

Please sign below to certify that you have understood the above information and that your answers are accurate and up-to-date. Any incorrect information can be dangerous to your health, so please inform your dentist of any changes.

Patient/Parent/Guardian | Date:

Dentist | Date: