**MEDICAL HISTORY FORM (STRICTLY CONFIDENTIAL)**

TITLE ………………SURNAME………………………………………………..... FIRST NAME……………..……................................

ADDRESS ……………………………………………………………………………............................................................................

TELEPHONE NUMBER …………………………................. MOBILE ………………………………......................................

 E MAIL …………………………………….............................................

|  |
| --- |
| **Doctors details** |
| Doctor name: S**urgery name:** |
| Address: Tel No. |

**Are you Give details Yes No**

|  |  |  |
| --- | --- | --- |
| Attending or receiving treatment from any doctor? |  |  |
| Taking any medicines or tablets from your doctor? (please list on page 2) |  |  |
| Taking or have you taken any steroids in thelast two years? |  |  |
| Allergic to any medicines, foods or materials |  |  |
| Likely to be pregnant? |  |  |

**Have You?**

|  |  |  |
| --- | --- | --- |
| Ever had jaundice, liver or kidney diseaseor hepatitis |  |  |
| Ever had rheumatic fever or been told that youhave a heart murmur? |  |  |
| Ever been told that you have a heart problemor had a heart attack? |  |  |
| Ever had infective endocarditis, or a heartvalve replaced or any form of heart surgery? |  |  |
| High or low blood pressure? |  |  |
| Had any blood tests recently? |  |  |
| Ever had a bad reaction to a local or generalanaesthetic? |  |  |
| Ever had a stroke? |  |  |
| Ever had a major operation or recently receivedhospital treatment? |  |  |
| Ever had your blood refused by the BloodTransfusion Service? |  |  |
| Ever been diagnosed or suspected as havingV CJD or being HIV positive |  |  |

**Do You? Give details Yes No**

|  |  |  |
| --- | --- | --- |
| Have a pacemaker? |  |  |
| Suffer from bronchitis or asthma? |  |  |
| Bruise easily or have you ever bled excessively? |  |  |
| Have fainting attacks, giddiness or epilepsy? |  |  |
| Have diabetes? |  |  |
| Carry a warning card? |  |  |
| Smoke and if yes how many a day? |  |  |
| Drink alcohol and if yes how many units a week? |  |  |

please give any other details which your dentist might need to know about regarding your CURRENT health

**PLEASE LIST BELOW ANY CURRENT MEDICATION**

|  |  |
| --- | --- |
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|  |  |

 The information that you provide on this form will help us treat you safely. Therefore we will ask you to complete

 it at the start of each new course of treatment.

**Do you give permission for us to contact you via text or email for – Appointment reminders Yes/No**

 **Marketing information Yes/No**

 **Next of kin…………………………………………………………………Contact details………………………………………………………**

 **Signed……………………………………………………………………………………………………..Date…………………………………………**

 **Recorded onto patients records by……………………………………………………………………………….Date……………………**

 **PLEASE RETURN TO 116 STATION ROAD NAILSEA BS48 1TB**