CONFIDENTIAL MEDICAL HISTORY FORM

Welcome to Grange Street Dental Practice, to obtain the best and safest treatment, we need to know of any factors which may affect your treatment

Grange Street Dental Practice
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Tel no: 01727 844461

BDA
British Dental Association

TITLE	FIRST NAME	SURNAME	DATE OF BIRTH
ADDRESS			POSTCODE
TELEPHONE NUMBER(S)			OCCUPATION
EMAIL			
DOCTORS NAME & ADDRESS / TEL NUMBER			

Please continue overleaf if you need more space to write

	YES	NO	DETAILS
1) Are you attending or receiving treatment from a doctor, hospital, clinic or specialist			
2) Are you taking any medicine from your doctor? (tablets, cream, ointments, injections, other)			
3) Are you taking or have you taken steroids in the last 2 years?			
4) Are you allergic to any medicines, food or materials? Do you have hayfever / eczema?			
5) Are you a smoker? If so, how many a day?			
6) Do you drink alcohol? If so, how many units a week?			
7) Have you had rheumatic fever or chorea (St. Vitus Dance)?			
8) Have you ever been told you have a heart murmur or heart problem, angina, blood pressure, heart attack?			
9) Have you had any blood tests, inoculations etc?			
10) Have you ever had your blood refused by the Blood Transfusion Service?			
11) Have you ever had a bad reaction to a general or local anaesthetic?			
12) Have you had a joint replacement?			
13) Have you been hospitalised? If yes, what for & when?			
14) Do you have arthritis?			
15) Do you have a pacemaker, or have you had any form of heart surgery?			
16) Do you suffer from bronchitis, asthma or other chest condition?			
17) Do you have fainting attacks, giddiness, blackouts or epilepsy?			
18) Do you have diabetes or does anyone in your family?			
19) Do you bruise easily or following a tooth extraction, surgery or injury have you or your family bled so as to cause you to be worried?			
20) Do you carry a warning card?			
21) Are there any other aspects concerning your health that you think the dentist should know about? Including liver disease / kidney disease / hepatitis			
22) Have you ever had a bad dental experience?			

Completed by: Patient / Guardian Signature: …….. Date:……

Have there been any changes in your health, medicines, injections or tablets since your last course of treatment? If so, please make changes above & sign below.

Yes / No Date: …… Sign: ……	Yes / No Date: …… Sign: ……	Yes / No Date: …… Sign: ……	Yes / No Date: …… Sign: ……