MEDICAL HISTORY

THE LYNDHURST DENTAL PRACTICE
thelyndhurstpractice.co.uk

Information provided is strictly confidential and will be held within the practice under the terms of General Data Protection Regulation of May 2018.

Name:	Preferred Name:
Address:	
Postcode:	Date of Birth:
Occupation:	Religion (optional):
Home Telephone:	Mobile Telephone:
Email address:	Preferred method of contact:

Do you consent to us leaving messages to remind you of appointments?	Yes / No
Please provide the name and telephone number of an emergency contact.	Name: Telephone Number:

During your initial visit you may be asked further questions in relation to your responses. On subsequent visits we may ask to update your medical history, so having a list of your medication with you is very useful.

Doctor's name and address:	

Are you receiving any treatment from your doctor at present?	Yes / No
Have you had any serious illnesses or been hospitalised in the last 5 years?	Yes / No
Have you ever received Human Growth Hormone treatment or had brain surgery before 1980?	Yes / No

Are you allergic to any medication?	Yes / No
Do you smoke or chew tobacco?	Yes / No, If Yes please state how much:
Do you drink alcohol?	Yes / No
What is your typical weekly intake (in units)	
Do you tend to drink:	Beer / Wine / Spirits

(Please Turn Over)

Please circle any of the following conditions you have ever suffered with:

Damaged or artificial heart valves. Heart murmur, rheumatic fever, infective endocarditis	Hepatitis, jaundice or liver problems
Angina, heart attack, stroke, TIA.	AIDS, HIV or CJD
High blood pressure or low blood pressure	Thyroid problems
Diabetes	Breathing problems- inc. TB, bronchitis or emphysema
Cancer	Painful or swollen joints
Sinus problems	Stomach ulcers or reflux
Allergies, Asthma or hay fever	Kidney disease
Blood disorders- e.g.anaemia	Epilepsy or fainting fits
Eye disorder	Depression or mental health issue
Heart pacemaker fitted	Osteoperosis/non-malignant bone disease

What medication do you take? (We can photocopy your repeat prescription)

_____

_____

_____

Have you ever taken medicine or had injections for your bones (e.g Bisphosphonates) or long term steroids? Yes/No

Do you take medication to thin your blood (including Aspirin)? Yes/No

Have you had any serious problems during or after dental treatment in the past?

_____

Women only:

Are you pregnant or breast feeding?	Yes / No
Do you take the contraceptive pill?	Yes / No

I give consent to my dental surgery to discuss my treatment with my doctor or other clinicians if necessary.

Patient signature: Date: Dentist's signature:

(FOLLOWING TABLE TO BE COMPLETED WITH YOUR DENTIST AT FUTURE APPOINTMENTS)

DATE	CHANGES / CONFIRM UNCHANGED	TEAM MEMBERS SIGNATURE