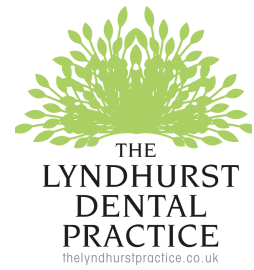


MEDICAL HISTORY



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:	
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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 | Osteoporosis/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