Bespoke Dental Care

Confidential Medical History Form

Mr / Mrs / Miss / Ms Surname: _____ Date of Birth: _____

Forename(s): _____ Sex: Male ☐ Female ☐

Address: _____

_____

Postcode: _____ Tel. (home): _____

Tel. (mobile): _____ Tel. (work): _____

Email: _____ Date of last received dental treatment: _____

Occupation: _____

Next of kin: _____ Relationship to you: _____

Next of kin contact tel: _____

Are you:	YES	NO	Details:
Attending or receiving treatment from a doctor, hospital clinic or specialist?	☐	☐	
Taking prescribed medicines (eg. tablets, ointments, injections, inhalers - including contraceptives or hormone replacement therapy)?	☐	☐	
Taken or have taken steroids in the last two years?	☐	☐	
Allergic to any medicines, foods or materials (eg. latex or rubber)?	☐	☐	
Pregnant or had a child within the last 12 months?	☐	☐	

Have you:	YES	NO	Details:
1. Had a rheumatic fever or chorea (St. Vitus Dance)?	☐	☐	
2. Had jaundice, liver, kindey disease or hepatitis?	☐	☐	
3. Ever been told you have a heart murmer or heart problem, angina, blood pressure or had a heart attack?	☐	☐	
4. Had any blood tests, inoculations etc.?	☐	☐	
5. Had your blood refused by the Blood Transfusion service?	☐	☐	
6. Had a bad reaction to general or local anaesthetic?	☐	☐	
7. Had a joint replacement?	☐	☐	
8. Ever had brain surgery?	☐	☐	
9. Had growth horome treatment before the mid 1980s?	☐	☐	
10. Been hospitalised? If "yes" what for and when?	☐	☐	
11. Had a close relative (parent, sibling, child, grandparent or grandchild) with Creztfeldt Jakob Disease?	☐	☐	

Please turn over

Do you:	YES	NO	Details:
1. Ever get cold sores?	☐	☐	
2. Have arthritis?	☐	☐	
3. Have a pacemaker, or have you had any form of heart surgery?	☐	☐	
4. Suffer from hayfever, eczema or any other allergy?	☐	☐	
5. Suffer from bronchitis, asthma or other chest conditions?	☐	☐	
6. Have fainting attacks, giddiness, blackouts or epilepsy?	☐	☐	
7. Have diabetes or does anyone in your family?	☐	☐	
8. Bruise easily? Or following a tooth extraction, surgeryor injury, do you or your family bleed so as to cause you concern?	☐	☐	
9. Carry a warning card?	☐	☐	
10. Have any infectious diseases (including HIV or hepatitis)?	☐	☐	
11. Suffer from any other serious illnessses?	☐	☐	

Drinking:	Number (in units):
How many units of alcohol do you drink per week? (eg. one unit is half a pint of lager, a single measure of spirit or a small glass of wine/aperitif).	

Smoking and chewing?	YES	NO	Previously	Quantity (per day):
Do you smoke any tobacco products now or did you in the past?	☐	☐	☐	
Do you chew tobacco, pan or supari now or did you in the past?	☐	☐	☐	

Please give any details which your Clinician may need to know, such as homeopathic remedies, self-prescribed medicines (eg. aspirin) or any other aspects of your health:

We will show this form at later visits so that you can tell us whether there has been any change in your general health.
All information will be kept strictly confidential.

Completed by Self / Patient / Guardian

Signature: _____ **Date:** _____ **Clinician Signature:** _____ **Date:** _____

Medical History Update:

Have there been any changes in your health, medicines, injections or tablets since your last course of treatment?

Yes ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Sig: _____	Sig: _____	Sig: _____	Sig: _____	Sig: _____	Sig: _____