

CONFIDENTIAL HISTORY FORM

Like all dentists, we ask patients for information about their general health to help us treat them safely. Please write your contact details below answer the health questions and then sign the form with date

SURNAME:FIRST NAMES:.....

TITLE:.....DATE OF BIRTH:.....

SEX: MALE/FEMALE (delete) OCCUPATION:.....

ADDRESS:

POSTCODE: Recommended by:

TELEPHONE: Home.....Work.....
Mobile.....E-mail

Please circle your preference for check-up reminders: sms text, email, letter.

Medical History

Name of GP:Telephone.....

Date of latest dental treatment:

Day: Month: Year:

<u>Are You Currently</u>	<u>Yes</u>	<u>No</u>	<u>Give Details</u>
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Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
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Receiving treatment from a doctor hospital or clinic	<input type="checkbox"/>	<input type="checkbox"/>	
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Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers, including contraceptives or hormone replacement therapy)?	<input type="checkbox"/>	<input type="checkbox"/>	
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Carrying a warning card?	<input type="checkbox"/>	<input type="checkbox"/>	
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<u>Do you suffer from:</u>	<u>Yes</u>	<u>No</u>	<u>Give details</u>
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Allergies to any medicines (e.g. antibiotics) substances (e.g. latex/rubber) or food?	<input type="checkbox"/>	<input type="checkbox"/>	
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Hay fever or eczema?	<input type="checkbox"/>	<input type="checkbox"/>	
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Asthma or other chest condition?	<input type="checkbox"/>	<input type="checkbox"/>	
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Fainting attacks, giddiness, blackouts or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches?	<input type="checkbox"/>	<input type="checkbox"/>	

Heart problems, angina, blood pressure problems, or stroke?	<input type="checkbox"/>	<input type="checkbox"/>	
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Diabetes or does anyone in your family?	<input type="checkbox"/>	<input type="checkbox"/>	
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Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	
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