MEDICAL HISTORY FORM PRIVATE AND CONFIDENTIAL

Title Name				
Date Of Birth				
Address				
Addiess				
Phone (Home/Mobile/Work)	Email Ad	ldress		
Occupation				
Are You Exempt From NHS Charges?				
My Last Dental Examination Was On				
GP Details				
How Did You Hear About Us?				
Next of Kin & Contact Details:				
Have you recently:				
······································	YES	NO	DETAILS	
Travelled to Sierra Leone, Liberia, Guinea in the last 2				
months? If so what was the purpose of the visit?				
If yes, have you experienced any flu like symptoms or				
fevers since your return?				
Ara Vau Curranthu				
Are You Currently:	YES	NO	DETAILS	
Receiving treatment from a doctor, hospital or clinic?	ILJ	INO	DLIAILS	
Taking any medications, pills or tablets?				
Carrying a warning card?				
Pregnant?				
Do You Suffer From:				
20 104 04 101 110111	YES	NO	DETAILS	
Allergies to any medication, substances (eg latex) or				
foods				
Hayfever or Eczema				
Bronchitis, asthma, or other chest conditions?				
Fainting attacks, giddiness, blackouts or epilepsy?				
Heart problems, angina, blood pressure or stroke?				
Diabetes or does anyone in the family?				
Arthritis?				
Bruising or persistent bleeding following extractions,				
surgery or injury? Any infectious diseases (including HIV or Hepatitis)?				
7 m y micetious discusses (moraumy m or reputato).				
Did you as a child or since have you had:				
Did you as a clinia of since have you had.	YES	NO	DETAILS	
Rheumatic fever or chorea?	123	110	DETAILS	
Liver disease (eg jaundice,hepatitis) or kidney disease?				
Blood refused by the Blood Transfusion Service?				
A bad reaction to a general or local anaesthetic?				
A joint replacement or other implant?				
Treatment that required you to be in hospital?				
Heart surgery?				
A close relative with Creutzfeldt Jakob Disease?				
How many units of alcohol do you drink per week?			Units per week	

	YES	NO	IN THE PAST	QUANTITY		
Do you smoke any tobacco products?						
Do you chew tobacco, paan or supari?						
Is There Anything Else Your Dentist	t Might Nee	ed To Know	About?			
COMPLETED BY (please circle):	SELF (Patien		PARENT	GUARDIAN		
SIGNATURE (Patient/Parent/Guardian):				DATE:	••••••	
DENTIST'S SIGNATURE:				DATE:		
LISTS OF MEDICINES						
1						
2						
3						
4						
5						
6			••••••		•••••••••••••••••••••••••••••••••••••••	
7						
8						
9						
10						
MEDICAL HISTORY UPDATE (FOR SUBSEQU	JENT VISITS O	NLY):				
Have there been any changes in the health (including information on smoking and dri	n information	on this form s	-	course of treatment at	this practic	
DATE	D	ETAILS OF CHA	ANGES	PATIENT'S SIGNATURE	DENTIST'S	
					SIGNATUR	
					SIGNATUR	
					SIGNATUR	
					SIGNATUR	
					SIGNATUR	
					SIGNATOR	