primecare

NHS

Providing NHS Dentistry

Medical history form

CONFIDENTIAL

We ask you for information about your general health to help us treat you safely. Please write your contact details below in BLOCK CAPITALS, answer the health questions and then sign the form on the back. We will use this form at later visits to discuss any changes in your general health. All the information will be kept strictly confidential by the people caring for you.

NHS number (if known):

Title: Surname: First name(s):

Sex: Female ❑ Male ❑ Date of birth / /

Address:

Postcode:

Home telephone number: Mobile:

Email address: Occupation:

Doctor's name and address:

When was your last routine dental appointment?

Please answer all questions in sections by ticking 'yes' or 'no'.

All the information you provide will be kept strictly confidential.

Do you suffer from:	Yes	No	Please give details here
Allergies to any medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods?	❑	❑	
Hayfever or eczema?	❑	❑	
Bronchitis, asthma or other chest conditions?	❑	❑	
Fainting, giddiness, blackouts, epilepsy?	❑	❑	
Heart problems, angina, blood pressure, or previously had a stroke?	❑	❑	
Diabetes (or does anyone in your family have the condition)?	❑	❑	
Bruising or persistent bleeding following injury, tooth extraction or surgery?	❑	❑	
Any infectious diseases (including HIV and hepatitis)?	❑	❑	
A neurological disorder (e.g. multiple sclerosis, Parkinson's disease, Huntington's Chorea)?	❑	❑	
Muscle problems (myopathy, dystrophy, paralysis)?	❑	❑	
Arthritis?	❑	❑	
Stomach ulcers/ hiatus hernia/ indigestion?	❑	❑	

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Did you as a child, or since, have:

Did you as a child, or since, have:	Yes	No	Please give details here
Rheumatic fever or chorea?	❑	❑	
Liver disease (e.g. jaundice, hepatitis) or kidney disease?	❑	❑	
Any other serious illness?	❑	❑	
Have you ever had blood refused by the Blood Transfusion Service?	❑	❑	
A bad reaction to general or local anaesthetic?	❑	❑	
A joint replacement or other implant?	❑	❑	
Treatment that required you to be in the hospital?	❑	❑	
Heart surgery?	❑	❑	
Brain surgery?	❑	❑	
Growth hormone treatment before the mid 1980s?	❑	❑	
A close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease (CJD)?	❑	❑	

Drinking How many units of alcohol do you drink in a week? (A unit is half a pint of lager, a single measure of spirits or a small glass of wine.)

Units per week

Smoking and chewing

Do you smoke any tobacco products now (or did you in the past)? Per day

Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)? Times per day

Are you currently:

Are you currently:	Yes	No	Please give details here
Pregnant?	❑	❑	
Carrying a medical warning card?	❑	❑	
Receiving treatment from a doctor, hospital or clinic?	❑	❑	

Taking any prescribed medicines (e.g. tablets, ointment, injections or inhalers, eye drops, suppositories, nebulisers, the contraceptive pill or HRT)? Please give details below.

Drug/medicine	dose	Drug/medicine	dose

Is there any other information you feel your dentist may need to know about, such as self-prescribed medicines (e.g. aspirin)?

Medical history update

Please check that the health information on this form is correct (including information on tobaccouse and alcohol consumption). If any details have changed, please amend as necessary or note any changes below.

Date	No change	List any changes below	Patient's initials

Form completed by: (please circle) Self Parent Guardian

Signature Date