TERRACE DENTAL CARE

Confidential Medical History Form

In order to help us treat you safely we require information about your general health. We will use this form at appointments to discuss any changes to your health. All information is kept strictly confidential by the dental team.
Please complete the form below and sign the back page.

Personal Details	
Title:	**Full Name:**
Date of Birth:	**Sex: Male ☐ Female ☐**
Home Telephone:	
Mobile Telephone:	
E-mail:	
Address:	
Postcode:	
Occupation/Current School:	
Emergency Contact Details:	
Name:	
Telephone Number:	
Relationship to you:	
Doctors details:	
Doctors Name:	
Telephone Number:	
Address:	

Do you or have you suffered from any of the following?

Asthma ☐	**High/low blood pressure ☐**
Bronchitis ☐	**Migraines ☐**
Diabetes ☐	**Angina ☐**
Epilepsy ☐	**Heart disease ☐**
Fainting ☐	**Heart attack ☐**
Blackouts ☐	**Heart surgery ☐**
Giddiness ☐	**Replacement heart valve ☐**
Stroke ☐	**Hepatitis ☐**
Hip/Knee replacement ☐	**Jaundice ☐**
Pacemaker ☐	**Tuberculosis ☐**
Sinus problems ☐	**Rheumatic fever ☐**
Arthritis ☐	**HIV/AIDS ☐**
Kidney disease ☐	**Liver disease ☐**

I do not/have not suffered from any of the above ☐
If yes to any of the above conditions please give details below:

Have you ever taken any of the following bisphosphonate medication? (Alendronic acid, Fusamax, Fosavance, Didronel, Disodium Etidronate, Disodium Pamidronate, Aredia, Ibandronic acid, Bondronat, Bonviva, Risedronate Sodium, Actonel, Sodium Clodronate) Yes ☐ No ☐

Do you carry a medical warning card? Yes ☐ No ☐
Do you suffer from bruising/persistent bleeding following injury/tooth extraction/surgery? Yes ☐ No ☐
Have you ever had blood refused by the blood transfusion service? Yes ☐ No ☐
Have you ever had a bad reaction to a general or local anaesthetic? Yes ☐ No ☐
Are you pregnant/possibly pregnant? Yes ☐ No ☐

Are you currently receiving treatment from a hospital/doctor/clinic?
Yes ☐ No ☐ (Please give details)

Are you taking any prescribed medications?
Yes ☐ No ☐ (Please list in the space below)

Have you ever had treatment that required you to be in hospital?
Yes ☐ No ☐ (Please give details)

Have you suffered from any serious illness or infectious disease?
Yes ☐ No ☐ (Please give details)

Do you have any allergies (medicines/latex/food etc)?
Yes ☐ No ☐ (Please give details)

Smoking
Do you smoke any tobacco products (or have you in the past)?
Yes ☐ No ☐ In Past ☐ _____ times per day

Do you chew tobacco, pan, gutkha or supari (or have you in the past)?
Yes ☐ No ☐ In Past ☐ _____ times per day.

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

Do you have any difficulties receiving dental treatment, for example significant dental anxiety, increased gag reflex, keeping your mouth open?
Please give details:

Your safety is our priority; dental chairs have a safe working weight limit. Please record your weight below:

Completed by:
Patient ☐ Parent ☐ Guardian ☐ Carer ☐

Patient signature_____ Date_____

Dentist signature_____ Date_____

Medical History Update
We like to ensure that your details are up to date. Please check the form and amend any changes and sign below.

Date	Any changes	Signature