Pt Reference Number:	

Confidential Medical History Form

First Name:		Surname:
Date of birth		
Address		
Email		
Telephone number		

Are you happy to be contact for reminders?	YES	NO
From time to time we may contact you with details of promotions/services we provide. Please tick yes/no to confirm if you are happy for us to do so	YES	NO

How did you hear about this practice? Please tick					
Website	Family or friend	Local area	Magazine	Radio	NHS choices

PLEASE ANSWER ALL OF THE QUESTIONS with x

	YES	NO		YES	NO
Are you seeing a doctor for any reason?			Liver/ kidney disease?		
Diabetes?			Asthmatic?		
Carrying any warning cards			Do you have a high sugar/acid intake?		
Any allergies? (please list below)			Have you had brain surgery		
High or low blood pressure			Creutzfeldt–Jakob disease?		
Do you suffer with angina			Do your gums bleed?		
Did you have a stroke			Pregnant?		
Have you had heart surgery			HIV/hepatitis?		
Normal bleeding after cutting or tooth removal?			Problems with local or general anaesthetic?		
Do you smoke? If yes how many?			Do you drink alcohol? Units.......		
Taking any medications? (please list below)			Any other illnesses not listed above		

GP details Address: Tel:
Please note down any medications you are currently taking
Please list any allergies

Please update your dentist as soon as possible if anything above changes

Signature:	Date: