|  |  |
| --- | --- |
| Pt Reference Number: |  |

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**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 detailsAddress: 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: |