## Confidential Medical History Form

Surname

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

First Name/s			Title
Sex	Male Female		
Date of Birth	day month ye	ear	
Address			
		Postcode	
Telephone	home		
•	mobile		
In the event of a	n emergency, please contact:	Name	
		Number	
Email			
Occupation			
Doctor's name	and address		
Dostow's tolomb			

Are you currently	yes	no	Give details
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines (eg tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?	i	i	
Carrying a medical warning card?			
Pregnant or possibly pregnant?			
Have you ever suffered from	yes	no	Give details
Allergies to medicines (eg penicillin), substances (eg latex/rubber) or foods?			
Bronchitis, asthma or other chest condition?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart problems, angina, blood pressure problems, or stroke?			
Diabetes (or does anyone in your family)?			
Bone or joint disease?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Liver disease (eg jaundice, hepatitis) or kidney disease?			
Any other serious illness or infectious disease?			
Blood refused by the Blood Transfusion Service?			
A bad reaction to general or local anaesthetic?			

Treatment that required you to be in hospital?  Heart surgery?			
Alcohol			
How many of units of alcohol do you dr (A unit is half a pint of lager, a single me or a single glass of wine/aperitif.)			units per week
Tobacco use	yes	no	in past
Do you smoke any tobacco products now (or did you in the past)?			times per day
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)?			times per day
Please give any other details which			
such as self-prescribed medicines	eg asp	oirin) (	or any disabilities you may have

Completed by (please tick)	self	parent	guardian
Patient's signature		Date _	
Dentist's signature		Date	

## Medical history update

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

Date	No change	List any changes below	Patient's initials
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