The Parade Dental Practice.
Confidential Medical History Form.

To obtain the best and safest treatment, your dentist needs to know of any problems which may affect your treatment.

Full Name :		
Date of Birth :		Male / Female
Address and Postcode : Email address		
Telephone Number	Home :	
	Work :	
	Mobile :	
	Occupation :	
Doctor's Name & Address and Telephone Number:		

	Yes	No	Details
Are you: Attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Are you an expectant or nursing mother?			
Taking any medicines from your doctor? Please list (Tablets, creams, ointments, injections, contraceptive pill, other)			
Taking or have you taken steroids in the last two years?			
Allergic to any medicines, foods or materials? (Please list)			
Have you: Had rheumatic fever for chorea (st Vitus Dance)?			
Had jaundice, liver, kidney disease or hepatitis?			
Ever been told you have a heart murmur or heart problem, angina, blood pressure, heart attack?			
Had a bad reaction to a general or local Anaesthetic?			
Had a joint replacement?			
Been hospitalised? If so what for and when?			

PTO

	Yes	No	Details
Do you : Have arthritis?			
Have a pacemaker, or have you had any form of heart surgery? i.e Valve replacement Take anticoagulants (eg Warafarin/Clopidogrel)			
Suffer from hay fever, eczema or any other allergies?			
Suffer from bronchitis, asthma or any other chest conditions?			
Have fainting attacks, giddiness, blackouts or epilepsy?			
Have diabetes or does anyone in your family?			
Bruise easily, or following a tooth extraction, surgery or injury have you or your family bled so as to cause worry?			
Are you a smoker?			
Do you drink alcohol? Please state number of units per week (1 unit – half pint of lager, single measures of spirits or a small glass of wine).			
Do you carry a warning card?			
Ever get cold sores?			
Are there any other aspects concerning your health that you think your dentist should know about? (eg C.J.D)			
Please tick **OR TELL THE DENTIST** if you have any blood borne viruses including H.I.V?			

Form completed by : Self / Parent / Guardian. Signature :
Date :

Please read and check your medical history. If there have been any changes please amend and circle Y (yes)

Date……Y / N Patient Sign …… Dentist Sign ……

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