St Francis DENTAL PRACTICE

Confidential Medical History Form

We ask you information about your general health to enable us to treat you safely. Please write your contact details below, answer the health questions and sign the form when you have finished. We will use this form at later visits to discuss any changes in your general health. Information will be kept strictly confidential by the people caring for you.

Personal Details:

Title: Name:	Date of birth: Sex:
Address:	
Postcode:	Home telephone:
Mobile telephone:	Work telephone:
Email address:	Occupation:

In the event of an emergency, please contact:

Name:
Telephone number:
Relationship to you:

Doctor's Details:

Doctor's name:
Telephone number:
Address:
Postcode:

Medical History:

Are you currently receiving treatment from a doctor, hospital or clinic? Yes/No	Please give any details
Do you currently take any medication? E.g. tablets, ointments, inhalers or injections including contraceptives Yes/No	Please give any details
Do you carry a warning card?	Yes/No
Are you pregnant or possibly pregnant?	Yes/No

Have you ever suffered from: Yes/No	Please Give Details
Allergies to medicines (eg penicillin), substances (eg latex/rubber) or food?	
Bronchitis, asthma or other Chest condition?	
Fainting attacks, giddiness, blackouts or 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 units of alcohol do you Drink per week? (One unit is a half pint of lager, single measure of spirits or small glass of wine)	____ units per week

Smoking

Do you smoke tobacco products now(or did you in the past)?	Yes/No/In the past	___ times per day
Do you chew tobacco, pan now (or did you in the past)?	Yes/No/In the past	___ times per day

Please give any other details which your dentist may need to know about, such as self-prescribed medicines (eg aspirin) or any disabilities you may have

Completed by Self/Parent/Guardian(Please circle)

Patient Signature _____	Date _____
Dentist Signature _____	Date _____