CONFIDENTIAL MEDICAL HISTORY

(Please complete both sides)

ST OSWALD'S DENTAL SURGERY

Like all dentists, we ask patients for information about their general health to help us to treat them safely. Please write your contact details below, answer the health questions and then sign the form on the back page. All information will be kept strictly confidential.

Surname	Forename	Title	Date of Birth

Address	Doctor's Name / Address

ARE YOU CURRENTLY	YES	NO	PLEASE GIVE DETAILS
Pregnant (if applicable)			
Currently receiving medical treatment?			
Taking any prescribed medicines or drugs. **PLEASE LIST**			
Carrying a medical warning card?			

DO YOU SUFFER FROM	YES	NO	GIVE DETAILS
Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?			
Hay fever or eczema?			
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)?			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases (including HIV and hepatitis)?			

DID YOU, AS A CHILD OR SINCE, HAVE:	**YES**	**NO**	**GIVE DETAILS**
Rheumatic fever or chorea?			
Liver disease (e.g. jaundice, hepatitis) or kidney disease?			
Any other serious illness?			
A bad reaction to general or local anaesthetic?			
A joint replacement or other implant?			
Treatment that required you to be in the hospital?			
Heart surgery?			
Brain surgery?			
Growth hormone treatment before the mid-1980s?			
A close relative with Creutzfeldt Jakob Disease?			

DRINKING	**UNITS PER WEEK**
How many units of alcohol do you drink per week? (*A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitif.)*	*Units per week*

SMOKING AND CHEWING	**YES**	**NO**	**IN PAST**	**QUANTITY**
Do you smoke any tobacco products now (or did you in the past)? How many times per day?				*Units per day*
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)? How many times per day?				*Units per day*

PLEASE GIVE ANY OTHER DETAILS WHICH YOUR DENTIST MIGHT NEED TO KNOW ABOUT, SUCH AS SELF-PRESCRIBED MEDICINES (eg ASPIRIN)

FORM COMPLETED BY (Please tick) Self Parent Guardian

SIGNATURE:

DATE: