# Confidential Medical History

*St. Oswald's Dental Surgery*

## Personal Details

Title (Mr, Mrs. Miss, Ms, other title)

First Name

Surname

Gender ☐ Male ☐ Female

Date of Birth

Address

Post Code

| Home Telephone | Work Telephone |
|---|---|
| Mobile Telephone | Email |

Occupation

| Doctor Information | Emergency Contact |
|---|---|
| Name | Name |
| Address | Relation to you |
| Post Code | Telephone |

## Dental History

Do you have dental pain or a problem at present?

Do you become anxious or uncomfortable from dental treatment?

Are you interested in the following types of dental treatment?

- ☐ Improving gum health
- ☐ Replacing silver fillings or ugly crowns
- ☐ Seeing the dental hygienist
- ☐ Straighter teeth
- ☐ Filling spaces where teeth are missing
- ☐ Whitening
- ☐ Other

| Are you currently? | No | Yes | Give Details |
|---|---|---|---|
| Receiving treatment from a doctor, hospital or clinic? | ☐ | ☐ | |
| Carrying a medical warning card? | ☐ | ☐ | |
| Pregnant or possibly pregnant? | ☐ | ☐ | Due Date: |
| Taking any prescribed medications?<br>PLEASE LIST THEM ALL – or bring the repeat prescription list provided by your pharmacist. | ☐ | ☐ | |

| Have you ever had? | No | Yes | Give Details |
|---|---|---|---|
| Allergic reaction to medications (eg penicillin), substances (eg rubber/latex) or foods? | ☐ | ☐ | |
| Asthma, bronchitis, emphysema or another chest condition? | ☐ | ☐ | |
| Fainting attacks, giddiness, blackouts or epilepsy? | ☐ | ☐ | |
| Diabetes (or anyone else in your family)? | ☐ | ☐ | |
| Bone or joint disease, or taken medicine that affects your bones? | ☐ | ☐ | |
| Any other serious illness or infectious disease (e.g. HIV or Hepatitis)? | ☐ | ☐ | |
| Blood refused by the Blood Transfusion Service? | ☐ | ☐ | |
| A bad reaction to local or general anaesthetic? | ☐ | ☐ | |
| Treatment that required you to be in hospital? | ☐ | ☐ | |
| Bruising or persistent bleeding following injury, tooth extraction or surgery? | ☐ | ☐ | |
| Liver or kidney disease (e.g. jaundice or hepatitis)? | ☐ | ☐ | |
| High blood pressure? | ☐ | ☐ | |
| Angina or stroke? | ☐ | ☐ | |
| Heart Surgery? | ☐ | ☐ | |
| A pacemaker fitted? | ☐ | ☐ | |
| Unusual heart rhythms or murmurs, valve defects or replacement, previous infective endocarditis or hypertrophic cardiomyopathy? | ☐ | ☐ | |

| Tobacco and Alcohol | No | Yes/In Past |
|---|---|---|
| Do you smoke? | ☐ | _______ per day, for ________ years |
| Do you chew tobacco, pan gutkha or supari? | ☐ | _______ times per day |
| Do you drink alcohol? | ☐ | _______ units per week<br><br>A unit is half a pint of lager, a single measure of spirits or a small glass of wine. |

## How did you hear about the practice? (New patients only)

Patient /Parent/Guardian Signature.................................................. Date..............................