Medical History Form

Certain medical conditions can affect dental treatment and vice versa.
Please complete this form by ticking the appropriate boxes and answering the questions.
All details will be strictly confidential

Patient ID *(if known)*: _____ Date of birth: _____

Mr/Mrs/Miss/Ms/Master Sex: Male / Female

Surname: _____

Forename: _____ Tel no. (mobile): _____

Address: _____ Tel no. (home): _____

_____ Post Code:_____ Email: _____

ARE YOU:	Yes	No	*Details*
Attending or receiving treatment from a doctor, hospital, clinic or specialist?	☐	☐	
Are you an expectant or nursing mother?	☐	☐	
Taking any medicines from your doctor? (Tablets, creams, ointments, injection, contraceptive pill, other)	☐	☐	
Taking or have taken steroids in the last 2 years?	☐	☐	
Allergic to any medicines, foods, Materials?	☐	☐	

HAVE YOU:	Yes	No	*Details*
Had rheumatic fever or 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?	☐	☐	
Have you ever been hospitalised? If so, what for and when?	☐	☐	

DO YOU:	Yes	No	*Details*
Have arthritis?	☐	☐	
Have a pacemaker, or have you had any form of heart surgery?	☐	☐	
Suffer from hay fever, eczema, asthma or any other allergies?	☐	☐	
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?	☐	☐	

DO YOU:	Yes No	*Details*
Smoke or Chew Tabaco? If yes how many per week?	☐ ☐	
Drink Alcoholic beverages? How many units of alcohol do you consume per week? ½ pint beer/larger = 1 unit 1 small glass wine = 1 unit	☐ ☐	
Do you carry a warning card?	☐ ☐	
Please tick **OR TELL THE DENTIST** if you have any blood born viruses including H.I.V.	☐ ☐	
Are there any other aspects concerning your health that you think your dentist should know about? (eg C.J.D)	☐ ☐	

Dental Questionnaire (optional)

	Yes No
Do you have concerns about your breath?	☐ ☐
Are you happy with your smile?	☐ ☐
Are you happy with the colour of your teeth?	☐ ☐
Do you have old crowns which you feel are unattractive?	☐ ☐
If you wear dentures, would you be interested in a permanent replacement for them?	☐ ☐
Are you happy with having metal fillings in your mouth?	☐ ☐
Would you like them to be replaced with tooth coloured restorations?	☐ ☐
Are you anxious about dental treatment?	☐ ☐

If you are not sure of any of the questions, or if your medical circumstances change, please inform the dental surgeon.

Patient Signature …… Date …….

Dentist Signature …… Date …….