Confidential Medical History Form

Name: **DOB:**

Address:

Doctors Name:	
Address:	

Home Tel: **Work Tel:** **Mobile:** **Email:**

	Yes	No
ARE YOU		
Pregnant?	☐	☐
Receiving treatment from a doctor, hospital or clinic?	☐	☐
Taking any medicines?	☐	☐
Have you any infection or disease including HIV and Hepatitis?	☐	☐
HAVE YOU?		
Allergies to any medicines and materials?	☐	☐
Hayfever or Eczema?	☐	☐
Bronchitis. asthma or chest condition?	☐	☐
Heart problems including angina, blood pressure?	☐	☐
Diabetes (or does anyone in the family)?	☐	☐
Arthritis?	☐	☐
Bruising of persistent bleeding?	☐	☐
Stroke?	☐	☐
Fainting, giddiness, epilepsy?	☐	☐
Rheumatic fever?	☐	☐
Liver disease (including jaundice and hepatitis)?	☐	☐
Kidney disease?	☐	☐
Been hospitalised?	☐	☐
Bad reaction to anaesthetic?	☐	☐
Smoked?	☐	☐
Any other condition we should know about?	☐	☐

Occupation: _____

Our patients appreciate appointment reminders sent by text message. If you would prefer NOT to receive these messages you may opt out by ticking this box (but please remember that we do charge for wasted surgery time). ☐

Our specialists are actively involved in research and education. Patients are usually pleased to allow us to use records while maintaining anonymity. If you prefer us NOT to use your records in this way please tick the box. ☐

We have provided you with full information including terms and conditions of payment through our website and leaflets. If you feel uncertain about any aspect please tick here for a member of staff to contact you. ☐

To the best of my knowledge this information is correct and I give my permission for the dentist or anaesthetist to contact my doctor and to check any medical record available.

Signature: _____ Date: _____ Patient/Parent/Guardian