



diamonddental

@ Westbury Park

Healthy teeth for life

Confidential Medical History

Like all dentists, we ask patients for information about their general health to help us treat them safely. Please complete and sign this form and bring it with you to your consultation. All information will be kept strictly confidential.

Title.....Surname(s)

Forename(s)

Date of Birth Male Female

Address

.....

..... Post Code

Tel Home..... Tel Work

Tel Mobile E-mail.....

Occupation.....

Doctor's Name and Address.....

.....

Doctor's Tel.....

Are you currently:

Delete as appropriate

Give details

Pregnant? Yes No

Receiving treatment from a
Doctor, hospital or clinic? Yes No

Taking any prescribed medicines
(tablets, ointments, injections or
inhalers, including contraceptives
and HRT)? Yes No

Carrying a medical warning card? Yes No.

Do you suffer from:

Allergies to any medicines
(eg penicillin), substances
(eg latex/rubber) or foods? Yes No

Hay fever or eczema? Yes No

Bronchitis, asthma or other
chest condition? Yes No

Fainting attacks, giddiness,
blackouts or epilepsy? Yes No

Heart problems, angina, blood
pressure problems or stroke? Yes No

Diabetes (or anyone in the family)? Yes No

Arthritis? Yes No

Bruising or persistent bleeding
following injury, tooth extraction
or surgery? Yes No

Any infectious diseases
(including HIV and hepatitis)? Yes No

Did you, as a child or since have

Delete as appropriate

Give details

Rheumatic fever or cholera?	Yes	No
Liver disease (eg jaundice, hepatitis) or kidney disease?	Yes	No
Any other serious illness?	Yes	No
Blood refused by the Blood Transfusion Service?	Yes	No
A bad reaction to a general or local anaesthetic?	Yes	No
A joint replacement or other implant?	Yes	No
Treatment that required you to be in hospital?	Yes	No
Heart surgery?	Yes	No
A parent, sibling, child, grandparent or grandchild with Creutzfeldt Jakob Disease?	Yes	No

Drinking:

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

Do/did you smoke tobacco? Yes/No/In past

.....per day

Other details:

Please give any other details which your dentist might need to know about, such as self-prescribed medicines (eg. aspirin)

Completed by:

Self Parent Guardian

Signature..... Date.....

Any other details you would like us to know: