Confidential Medical History Form

Whyman House
Dental Practice

Patient Details			
Title:	First Name:		Surname:
DOB: / /	Sex: Male ☐ Female ☐	Occupation:	
Address: Postcode:			
Telephone(home):		Telephone(mobile):	
Email:			

Emergency Contact	
Name:	Telephone:
Relationship to you:	

Doctors Details	
Doctors Name:	Telephone:
Address: Postcode:	

Do you have: Hearing Loss? ☐ Sight Loss? ☐ Mobility Problems ☐

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 small glass of wine) .....units per week

Do you smoke tobacco products? Yes ☐ How many daily No ☐ In the past ☐

Do you chew tobacco, pan or use gutkha? Yes ☐ No ☐ In The Past ☐

Are you currently?	Yes	No	Give Details
Receiving treatment from a doctor, hospital, or clinic?			
Taking any prescribed medicines? (Including tablets, inhalers, injections, contraceptives, and ointments) Please list in detail or additional sheet if required.			
Taking any self-prescribed medicines/drugs? (Including pain killers or recreational drugs)			
Carry a medical warning card or bracelet?			
Pregnant or possibly pregnant?			Date Baby Due:

Have you ever had?	Yes	No	Give Details
Allergies to drugs (e.g., penicillin, chlorhexidine) plasters, latex or food?			
Bronchitis/ Asthma/ TB/ COPD/ Bronchitis/ Asthma/ TB/ COPD/ another chest condition?			

	Yes	No	Give Details
Epilepsy or other neurological disorder?			
Heart problems/ Angina/ High or Low blood Pressure/ Stroke/ Endocarditis/ Valve disease or Heart Surgery?			
Diabetes?			
Bone or joint disease? (Osteo or inflammatory arthritis, osteoporosis etc)			
Persistent bleeding or bruising after injury, tooth extraction & surgery?			
Are you taking blood anticlotting drugs e.g., Warfarin or Prothrombin Inhibitor?			
Are you taking bisphosphonate medication (e.g., Alendronic Acid)?			
Liver disease?			
Kidney or urinary tract disease?			
Do you have/have you had infections Hepatitis B, Hepatitis C or HIV?			
Mental Health Problems? (e.g., Alzheimer's Disease, Dementia, Depression, Schizophrenia or bipolar disorder)			
Learning Disability?			
Drug or Alcohol Addiction?			
An operation under general Anaesthetic in hospital?			
Other treatment that required you to be in hospital?			
Cold sores?			
Any other disabilities or conditions not listed above?			

Our dental chairs have a weight limit so for your safety we need to ask about your weight.

Do you weigh: Less than 21 stone? (133kg) ☐ Between 21 & 35 stone? (133-222kg) ☐ More than 35 stone? (222kg) ☐

Patient/Carer/Parent Signature:	Date
Dentist Signature:	Date
Completed By: Self ☐ Parent ☐ Guardian ☐	

Date	Any changes?	List Changes Below	Initials
		Alcohol: **units per week** **Smoke:** **per day**	
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