DORKING DENTAL CENTRE – *Confidential Medical History Sheet*

As recommended by the British Dental Association, we ask patients for information about their general health in order to help us treat them safely. Please fill in your contact details and answer the health questions, then sign and date. We will review the form with you at later visits so that you can tell us whether there has been any change in your general health. All information will be kept strictly confidential. *Please advise the dentist if you have a medical exemption certificate.*

Surname: _____ Forenames: _____ Title: _____

Address: _____

_____ Post Code: _____

It is very important that we are able to keep in touch with you, please provide as much information as possible.

Date of Birth: _____ email _____

Home Telephone: _____ Mobile: _____ Work: _____

Male / Female Occupation:_____ Date of last dental treatment: _____

Doctors Name and Address: _____

_____ Telephone: _____

Are You Currently	**Yes**	**No**	**Give Details**
Pregnant?			
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed or non prescribed medicines (e.g. tablets, ointments, injections or inhalers, including Contraceptives and hormone replacement therapy)?			
Carrying a medical warning card?			
Do You Suffer From	**Yes**	**No**	**Give Details**
Allergies to any medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods?			
Hay fever or eczema			
Bronchitis, asthma or other chest condition?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Problems with heart, angina, blood pressure or stroke?			
Diabetes (or does anyone in your family?)			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases (including HIV and hepatitis B or C)?			
Any history of blood transfusions in UK or overseas?			
Any history of new partners, unprotected sex or drug use?			
Any dentistry or operations carried out abroad?			
Any history of imprisonment?			
Do you have any tattoos or body piercings?			
Did you, as a child or since have:	**Yes**	**No**	**Give Details**
Rheumatic fever or chorea?			
Liver disease (e.g. jaundice, hepatitis) or kidney disease or renal dialysis?			
Any other serious illness?			
A bad reaction to general or local anaesthetic?			
A joint replacement or other implant?			
Treatment that required you to be in hospital?			
Heart surgery?			
Brain surgery?			
Growth hormone treatment before mid-1980's?			
A close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease?			
Have you ever been notified that you are at increased risk of CJD or vCJD for public health purposes?			
Do you drink? If yes, how many units per week?			Units per week
Do you smoke any tobacco products now (or did you in the past)? How many times per day?			How many per day?
Please give details of anything else your dentist might need to know about, such as self prescribed medicines (e.g. aspirin) or any disabilities you may have.			

Signature of patient: _____**Date:**_____ **(Parent or Guardian to sign for minors)**

How did you hear about us? _____