**CONFIDENTIAL MEDICAL HISTORY FORM**

It is important that you answer the questions accurately as some conditions/medications may affect your treatment. Please look at the following list and tick any of the conditions that apply to the patient. All information will be kept strictly confidential by the people caring for you. Please include parent/guardian contact details for patients under 16 years of age.

Forename: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile (if over 16): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian emergency contact details:

Parent/Guardian name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address if different from above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **HAVE YOU HAD OR DO YOU SUFFER FROM:****PLEASE GIVE DETAILS BELOW** | **Y** | **N** | **ARE YOU:** | **Y** | **N** |
| Heart problems, angina, blood pressure problems or strokes |  |  | Attending or receiving treatment from a doctor, hospital clinic or specialist? |  |  |
| * Rheumatic fever or cholera?
 |  |  | Taking any prescribed medicines? PLEASE STATE |  |  |
| * Liver or kidney disease, Jaundice or Hepatitis?
 |  |  | Taking anticoagulant treatment? PLEASE STATE |  |  |
| * Epilepsy?
 |  |  | Being treated with steroids? |  |  |
| * Fainting or blackouts?
 |  |  | Allergic to any medicines/substances eg.latex, nickel PLEASE STATE |  |  |
| * Asthma?
 |  |  | Pregnant or might be?  |  |  |
| * Bronchitis or other chest conditions?
 |  |  |  |  |  |
| * Hay Fever?
 |  |  | **DO YOU HAVE:** |  |  |
| * Eczema?
 |  |  | Autistic Spectrum Disorder (ASD)? |  |  |
| * Sickle cell or similar disease?
 |  |  | Sensory Processing Disorder or difficulties? |  |  |
| * Infectious diseases (inc HIV or hepatitis B or C)?
 |  |  | Do you have ADHD? |  |  |
| * Diabetes or anyone in your family?
 |  |  |  |  |  |
| * Arthritis?
 |  |  | **DO YOU:** |  |  |
| * A reaction to local anaesthetic?
 |  |  | Carry a medical warning card? |  |  |
| * Any major operations such as joint replacements or pacemakers?
 |  |  | Bleed excessively from cuts or if you have a tooth extraction?  |  |  |
| * Depression, anxiety or other mental illness?
 |  |  | Need any disability access? Eg. Wheelchair, hearing? |  |  |

*If you have answered YES to any of the above, please give details: (If you need more space, please use reverse side.)*

Drinking:

How much alcohol do you drink per week? \_\_\_\_\_Units per week (a unit is half a pint of lager, or single measure of spirit or wine)

Smoking:

Do you smoke tobacco products now?\_\_\_\_\_ How many times per day? \_\_\_\_\_ Or if in the past, how many per day? \_\_\_\_\_

Do you chew tobacco, pan, use gukha or supari now? How many times per day? \_\_\_\_\_ Or if in the past, how many per day?\_\_\_\_\_

Do you Vape? \_\_\_\_\_ How many times per day? \_\_\_\_\_ Or if in the past, how many times per day? \_\_

Declaration: completed by: Self O Patient O Guardian O

 Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_ /\_\_\_/ \_\_\_

Checked(dentist print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_ /\_\_\_ /\_\_\_