Confidential Medical History Form for thegallery Dental and Implant Centre

Title: First Names:	Surname:
Date of Birth (DD/MM/YYYY):	Male / Female:
Address:	Postcode:
Tel. (Home):	Tel. (Mobile):
Tel. (Work):	Occupation:
Email:	
Expectant mother: YES / NO	If yes, expected delivery date:
Name and address of GP:	
Where did you hear about our practice?	

Are you:	Yes	No	Give details:
Attending or receiving treatment from any Medical practitioner, hospital or specialist?			
Taking any medicines at all? (including tablets, liquids, creams, injections or other)			
Taking steroids, now or in the past 3 years?			
Allergic to anything? (Medicines, food, products etc.)			
Have you:	**Yes**	**No**	**Give details:**
Had rheumatic fever or chorea (St Vitus dance)?			
Had jaundice liver disease or kidney disease?			
Ever been told that you have a heart murmur or heart problem, angina, high blood pressure or heart attack?			
Had any blood tests or inoculations? (give result)			
Ever had blood refused by the transfusion service?			
Had a bad reaction to a local or general anaesthetic?			
Had a joint replacement?			
Been Hospitalised? If “yes”- what for?			
Do you:	**Yes**	**No**	**Give details:**
Have arthritis?			
Have a pacemaker or had heart surgery?			
Suffer from hay fever, allergy, asthma or chest disease?			
Have fainting attacks, giddiness, blackouts or epilepsy?			
Have diabetes, or is there a family history?			
Bruise easily, or bleed excessively from cuts or extractions?			
Carry a warning or medicine dosage card?			
Ever get cold sores?			
Is there anything else your clinician should know about?			

Date: Name: Signed:

Completed by: SELF / PARENT / GUARDIAN

AMENDMENTS: Please use a different coloured pen to mark changes in medication or condition (second, third visit etc.). Date and sign in the same colour at the bottom - this enables us to track amendments.

Date: Signed: Date: Signed:

Date: Signed: Date: Signed: