Confidential Medical History Form

Surrey Quays Dental Practice
Tel: 020 7231 7912

Title: Mr/Mrs/Miss/Ms/Master/Other

Name:

Address:

Doctors Name:	
Doctors Address:	

Home Tel:

Mobile:

Work Tel:

DOB:

Email:

NHS no:

National Insurance no:

Certain medical conditions can affect dental treatment. Please complete this form by ticking the appropriate boxes and answering the questions

IF YOU ANSWER 'YES' TO ANY QUESTIONS PLEASE SUPPLY DETAILS IN THE BOX BESIDE EACH QUESTION

IF YOU ARE NOT SURE OF ANY OF THE QUESTIONS, OR IF YOUR MEDICAL CIRCUMSTANCES CHANGE, PEASE INFORM THE DENTAL SURGEON

Do you have or have you ever suffered from	Yes	No
Rheumatic fever?	☐	☐
Any heart complaint, heart surgery or stroke?	☐	☐
Diabetes?	☐	☐
Epiliepsy or fainting attacks?	☐	☐
Chronic bronchitis or asthma?	☐	☐
Hepatitis?	☐	☐
Excessive bleeding?	☐	☐
High blood pressure?	☐	☐
Are you		
Allergic to any medicines/substances/latex?	☐	☐
At present taking any medicines or tablets?	☐	☐
Pregnant?	☐	☐
In the past 2 years have you		
Undergone any operations?	☐	☐
Been treated with hydro-cortisone or corticosteroids?	☐	☐
Have you ever had a joint replacement operation?	☐	☐
Please tick or TELL THE DENTIST if you are HIV positive	☐	☐
What is your weekly consumption of alcohol?	☐	☐
If you smoke, what is your average per week?	☐	☐
IS THERE ANY OTHER CONDITION THAT YOUR DENTIST SHOULD BE AWARE OF?	☐	☐
IF YOU HAVE ANSWERED 'NO' TO ALL THE ABOVE QUESTIONS PLEASE CONFIRM THAT YOU KNOW OF NO MEDICAL ISSUES THAT MAY AFFECT ANY DENTAL TREATMENT	☐	☐

To the best of my knowledge this information is correct and I give my permission for the dentist or anaesthetist to contact my doctor and to check any medical record available.

Signature: Date: Patient/Parent/Guardian Dentist