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Confidential Medical History Form

Welcome to the Christensen Dental Practice. In order to provide the best and safest care for you, we would be grateful if you could complete this form. Any information given will be kept strictly confidential. Please also inform us if there are any changes to your name, address or telephone number.

Name	
Date of Birth	Title: Mr / Mrs / Miss
Address	
Postcode	
Telephone	Mobile
Next of Kin	Contact Number
Your doctor's surgery	

Are You?	Yes	No	If yes, please provide details
Receiving treatment from any doctor?	<input type="checkbox"/>	<input type="checkbox"/>	
Taking any medicines / tablets from your doctor?	<input type="checkbox"/>	<input type="checkbox"/>	
Taking / have taken any steroids in the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	
Please list any medicines and/or steroids you are taking currently:			
.....			
.....			
.....			
.....			
Allergic to any medicines or materials?	<input type="checkbox"/>	<input type="checkbox"/>	
Likely to be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	

Have You?	Yes	No	If yes, please provide details
High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
A heart problem or had a heart attack?	<input type="checkbox"/>	<input type="checkbox"/>	
Had rheumatic fever or a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	
Had infective endocarditis or had any heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
Had a blood test recently?	<input type="checkbox"/>	<input type="checkbox"/>	
Ever had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>	
Had a bad reaction to local or general anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>	

Please Turn Over

Have You? **Yes** **No** **If yes, please provide details**

Had a major operation or recently been in hospital?			
Ever had blood refused by the Blood Transfusion Service?			
Ever been diagnosed or suspected as having V-CJD or being HIV-positive?			
Ever been diagnosed with any of the following: ADHD, Asperger Syndrome, Autism or Dyspraxia?			

Do You? **Yes** **No** **If yes, please provide details**

Have a pacemaker?			
Have diabetes?			
Carry a warning card?			
Carry any emergency medication e.g. EpiPen?			
Suffer from asthma or bronchitis?			
Suffer from cold sores?			
Bruise easily or have you ever bled excessively?			
Have fainting attacks, giddiness or epilepsy?			
Have a history of mental illness or eating disorders?			
Smoke? If yes, how many a day?			
Drink alcohol? If yes, how many units a week?			

Are there any other aspects of your health that you feel we should know about?

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We are happy to send you a reminder for when your appointments are due. If you would like to receive an appointment reminder, please select your preferred method:

Text	
Postcard	
Email, please provide preferred email address	
No thank you	

You details will not be used for marketing purposes and will only be passed to a third party (e.g. referring you to a specialist) with your consent. Our policies regarding the handling of your personal information are available to view in our reception area.

Thank you for your help and co-operation.

Patient's Signature _____ **Date** _____