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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? | | | |
| Taking any medicines / tablets from your doctor? | | | |
| Taking / have taken any steroids in the last 2 years? | | | |
| Please list any medicines and/or steroids you are taking currently:<br>……<br>……<br>……<br>…… | | | |
| Allergic to any medicines or materials? | | | |
| Likely to be pregnant? | | | |

| **Have You?** | **Yes** | **No** | **If yes, please provide details** |
|---|---|---|---|
| High blood pressure? | | | |
| A heart problem or had a heart attack? | | | |
| Had rheumatic fever or a heart murmur? | | | |
| Had infective endocarditis or had any heart surgery? | | | |
| Had a blood test recently? | | | |
| Ever had a stroke? | | | |
| Had a bad reaction to local or general anaesthetic? | | | |

**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?

……
……
……
……

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 | |

Your 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** _____