This section to be completed by reception:

Dentist:	Appointment Date:	Claiming:	Serial number:

Confidential Medical History form

Where did you hear about our Practice?
e.g. website, radio, family/friends etc

Your dentist needs to know of any problems which may affect your treatment.
Please answer all questions as accurately as possible.

HEIGHT:		**WEIGHT:**	
Title (Mr, Mrs etc)		**Occupation**	
Surname		**Telephone home**	
First name		**Telephone mobile**	
Date of birth		**Expectant mother**	
Sex		**Doctor's name**	
Address:		**Doctor's address**	
How long have you resided in United Kingdom?		years	months
National Insurance Number			

	Please tick		
ARE YOU	**YES**	**NO**	**DETAILS**
1. Attending or receiving treatment from a doctor, hospital, clinic or specialist?			
2. Taking any medicines or tablets (including creams/ointments)? **Please give details**			
3. Being treated or have been treated with steroids in the past 2 years?			
4. Allergic to any medicines or tablets?			
5. Allergic to any other things?			
HAVE YOU	**YES**	**NO**	**DETAILS**
1. Had rheumatic fever?			
2. Ever suffered from jaundice or hepatitis?			
3. Been told that you have a heart complaint?			
4. Ever had your blood refused by the Blood Transfusion Service?			
5. Ever had a bad reaction to a general or local anaesthetic?			
6. Ever had an orthopaedic joint replacement operation?			
DO YOU	**YES**	**NO**	**DETAILS**
1. Bleed excessively from cuts or if you have a tooth extracted?			
2. Suffer from bronchitis, asthma or any other chest condition?			
3. Suffer from diabetes?			
4. Have blood pressure problems?			
5. Suffer from epilepsy?			

If there are any other aspects of your health that you feel may be relevant to your treatment & which the dentists should be aware of please give details here

Completed by self/parent/guardian **Signature**_____ **Date** _____