Confidential medical history form

CHESHIRE Denture Clinic

We ask for information about your general health and well-being to help us treat you safely. **PLEASE COMPLETE IN BLOCK CAPITALS.**

We will use this form to discuss any changes to your general health. All information will be kept strictly confidential by the people caring for you.

Patient details:

NHS number:	(applicable to NHS patients only)		
Patient ID no:			
Date of birth			
Email:			
Occupation:			
Doctor's name:		Doctor's tel:	
Doctor's address:			

1. Are you currently: (Please answer all of the questions below by ticking 'yes' or 'no'. If you answer 'yes', please provide additional details).

Receiving any medical treatment?	Yes:		No:		Details:	
Taking, or have taken steroids in the last two years?	Yes:		No:		Details:	
Pregnant, or possibly pregnant?	Yes:		No:		Details:	
Taking Bisphosphonates? (used for hormone replacement therapy, menopause and osteoporosis)	Yes:		No:		Details:	
Taking the contraceptive pill or hormone replacement therapy?	Yes:		No:		Details:	
Taking prescribed medication? (if yes, please list)	Yes:		No:		Details:	

2. Have you ever had: (Please answer all of the questions below by ticking 'yes' or 'no'. If you answer 'yes', please provide additional details).

Allergies to medicines, foods or materials? (e.g latex, runner)	Yes:		No:		Details:	
Jaundice, liver/kidney disease or hepatitis?	Yes:		No:		Details:	
A heart murmur or heart problem, angina, high blood pressure or heart attack	Yes:		No:		Details:	
Your blood refused by a Blood Transfusion Centre?	Yes:		No:		Details:	
A bad reaction to a general or local anaethetic?	Yes:		No:		Details:	
Bone or joint disease?	Yes:		No:		Details:	
Brain surgery?	Yes:		No:		Details:	
Been hospitalised? (if yes, what for and when?)	Yes:		No:		Details:	

3. Do you?: (Please answer all of the questions below by ticking 'yes' or 'no'. If you answer 'yes', please provide additional details).

Have a close relative (parent, sibling, child, grandparent/child) with Creutzfeldt-Jakob disease?	Yes:		No:		Details:	
Have Arthritis?	Yes:		No:		Details:	
Have a pacemaker or have you ever had any form of heart surgery?	Yes:		No:		Details:	
Suffer from Hay-fever, Eczema or any other allergy?	Yes:		No:		Details:	
Suffer from Asthma or other chest conditions?	Yes:		No:		Details:	
Have any allergies to any drugs or chemicals?	Yes:		No:		Details:	
Have fainting attacks, giddiness, blackouts or Epilepsy?	Yes:		No:		Details:	
Have Diabetes? – or does anyone in your family?	Yes:		No:		Details:	
Bruise easily or bleed heavily following injury, surgery or a tooth extraction – or does anyone in your family?	Yes:		No:		Details:	
Carry a medical warning card?	Yes:		No:		Details:	
Ever get Cold sores?	Yes:		No:		Details:	
Have any infectious diseases (including HIV or Hepatitis)?	Yes:		No:		Details:	
Suffer from any other serious illness?	Yes:		No:		Details:	
Suffer from Sleep Apnoea?	Yes:		No:		Details:	
Suffer from, or have you ever suffered from any form of mental illness?	Yes:		No:		Details:	

4. Alcohol and tobacco usage: (A unit of alcohol is half a pint of lager, a single measure of spirits, or a single glass of wine/aperitif)

Do you consume alcohol? (if so, please give an indication number of units consumed per week)	Yes:		No:		Details:	
Do you currently smoke any tobacco products? (if so, please give an indication of quantity per day)	Yes:		No:		Details:	
Do you currently chew tobacco, pan, gutkha or supari? (if so, please give an indication of quantity per day)	Yes:		No:		Details:	
Have you ever used any tobacco products? (if so, please give an indication of quantity per day)	Yes:		No:		Details:	

5. Further medical information:

Please give any other details which your dentist might need to know (e.g self-prescribed medicines such as Aspirin)

6. Signature: (if not completed by patient, please also state relationship to patient)

Completed by:	Signed:	Date: