Epsom DENTAL CARE

MEDICAL HISTORY FORM

Your history

We ask you for information about your general health to help us treat you safely. Please write your contact details below, answer the health questions and then sign the form on the back page. We will use this form at later visits to discuss any change in your general health. All information will be kept strictly confidential by the people caring for you.

Title:	Last name:		
Preferred name:	First name:		
	Date of birth:	Sex: Male ☐	Female ☐
NHS Number:			
Address:			
		Postcode:	
Home telephone number:			
Mobile telephone number:		Occupation:	
Email address:			

Emergency contact

Their name:	
Their telephone number:	Their relationship to you:

Doctor's details

Doctor's name:	
Doctor's telephone number:	
Address:	
	Postcode:

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Are you currently	yes / no	Please give details
Receiving treatment from a doctor, hospital or clinic?	☐ ☐	
Taking any prescribed medicines (e.g. wharferin, bisphosphonates, or other tablets, ointments, injections, or inhalers, including contraceptives, & hormone replacement therapy)?	☐ ☐	
Carrying a medical warning card?	☐ ☐	
Pregnant or possibly pregnant?	☐ ☐	

Have you ever had	yes / no	Please give details
Allergies to medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods?	☐ ☐	
Bronchitis, asthma, or other chest condition?	☐ ☐	
Fainting attacks, giddiness, blackouts, epilepsy?	☐ ☐	
Heart problems, angina, blood pressure problems, or stroke?	☐ ☐	
Diabetes (or a family history of)?	☐ ☐	
Bone or joint disease?	☐ ☐	
Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐ ☐	
Kidney disease or liver disease (e.g. jaundice, hepatitis)?	☐ ☐	
Any other serious illness or infectious disease?	☐ ☐	

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Have you ever had	yes / no	Please give details
Blood refused by the Blood Transfusion Service or any other agency abroad?	☐ ☐	
A bad reaction to general or local anaesthetic?	☐ ☐	
Treatment that required you to be in hospital?	☐ ☐	
Heart surgery or a stent?	☐ ☐	
Any form of mental illness (e.g. depression, anxiety, stress, eating disorders)?	☐ ☐	

Alcohol	Please give details
How would you describe your consumption of alcohol? Non-drinker, modest, moderate, more than is probably good for me, heavy?	

Smoking	yes / no / in the past	
Do you now or did you used to smoke tobacco products?	☐ ☐ ☐	____times per day
Do you now or did you used to chew tobacco, paan, use gutkha, supari, or betel?	☐ ☐ ☐	____times per day
Do you now or did you used to vape/use electronic cigarettes?	☐ ☐ ☐	____times per day

Please give any other details which your dentist might need to know about such as self-prescribed medicines (e.g. aspirin) or any disabilities or health concerns you may have.

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MEDICAL HISTORY FORM

Medical history update

Form completed by? Self ☐ Parent ☐ Guardian ☐ Other ☐ (please state):

Patient signature: Date:

Dentist signature: Date:

Please check that the health information in this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

Date:	Any changes?	List changes below:	Patient Initials:

Your dentist might ask you additional questions about aspects of your lifestyle or diet that could be relevant to your oral health.