CONFIDENTIAL

MEDICAL HISTORY FORM

Alexandra Dental Practice

To provide you with safe and effective treatment your dentist needs to know some details about your general health. Please complete this form, giving as much detail as possible.

Title First name(s) Surname

Date of birth , , Occupation

Home phone number Mobile number

House name or number Post code

Your email address

Name of your doctor and the name of the practice you attend

Please give details of someone we can contact in case of emergency.

Name Phone number

If you are new to the Practice, How did you find out about us?

Are you taking any tablets, medicine, inhalers, ointments etc.? Yes/No. IMPORTANT: Please list the names of all medication below:

	Yes	No	Details
Do you suffer from Cold sores			
Are you likely to be pregnant?			
Are you receiving any treatment from a doctor, hospital, clinic etc.			
Are you allergic to any substance, e.g. penicillin?			
Have you had a heart problem, angina, high or low blood pressure, heart attack or stroke?			
Have you had rheumatic fever?			
Have you had asthma, bronchitis or any chest infection?			
Have you had any operations in hospital?			
Have you had a heart valve replaced?			
Have you had a bad reaction to local or general anaesthetic?			
Have you had any blood related diseases e.g. Anaemia, leukaemia?			

CONFIDENTIAL

MEDICAL HISTORY FORM

Have you had any fainting attacks, fits, blackouts or epilepsy?			
	Yes	No	Details

PLEASE TURN OVER

C?			
Have you been diagnosed with Creutzfeldt-Jakob disease (**CJD**)?			
Do you have arthritis?			
Do you have a pacemaker?			
Do you have diabetes? Please specify type I or II			
Do you carry a warning card?			
Do you bleed excessively or bruise easily?			
Do you take warfarin. If so what was your latest INR?			
Do you take or have you ever taken steroids?			
Do you smoke? If so how many cigarettes a day?			
Do you drink alcohol? If so how many units in an average week?			

Any other information?

Consent		
Do you consent for us to contact you by phone/text/email/letter	Yes	No
Are you happy for us to leave a message for you (answer phone / family member)	Yes	No
Are you happy for a family member to make or changes appointments for you	Yes	No
If yes please give names(s)		
Are you happy for us to discuss any aspect of your dental treatment with a family member or partner	Yes	No
If yes please give names(s)		

Note: Please let us know if you wish to change any aspect or remove your consent in the future.

Completed by self/parent/carer

Signature _____ Date ____ , ____ , ____

Dentist's signature _____

Please check all the above information, make any amendments and sign below.

Review date	Patient signature	Dentist signature		Review date	Patient signature	Dentist signature
/ /				/ /		
/ /				/ /		
/ /				/ /		
/ /				/ /		

CONFIDENTIAL

MEDICAL HISTORY FORM

/ /				/ /		
/ /				/ /		