4-8 Church Street, Shoreham by Sea, BN43 5DQ
tel: 01273 453229 email: 2th@church-house.com

CONFIDENTIAL MEDICAL HISTORY

to provide the best and safest treatment, your dentist needs to know of any problems that may affect you

Title: First name: Surname:

Address: Postcode:

Tel. numbers Home: Work: Mobile:

Date of birth: Occupation: Email:

Name of doctor and surgery:

Next of kin: Tel. number:

If new to the Practice, how did you find us?

	yes	no	details
Are you receiving treatment from a medical professional?	❑	❑	
Are you taking any medicines from your doctor?	❑	❑	
Are you taking or have taken steroids in the last 2 years?	❑	❑	
Are you allergic to any medicines, food or materials?	❑	❑	
Have you had Rheumatic Fever or Chorea (St Vitus Dance)?	❑	❑	
Have you had jaundice, liver or kidney disease or hepatitis?	❑	❑	
Have you ever had a heart attack or other heart problems?	❑	❑	
Do you suffer from high / low blood pressure?	❑	❑	
Do you have a pacemaker or had any form of heart surgery?	❑	❑	
Have you had any blood tests, inoculations, etc?	❑	❑	
Have you had your blood refused by the Transfusion Service?	❑	❑	
Have you had a bad reaction to a general or local anaesthetic?	❑	❑	
Have you had a joint replacement?	❑	❑	
Have you been hospitalised? If 'yes', what for and when?	❑	❑	
Do you have arthritis?	❑	❑	
Do you suffer from hay fever or eczema?	❑	❑	
Do you suffer from any chest condition?	❑	❑	
Do you have fainting attacks, giddiness, blackouts or epilepsy?	❑	❑	
Do you or anyone in your family have diabetes?	❑	❑	
Do you bruise easily?	❑	❑	
Do you or your family have any bleeding disorders?	❑	❑	
Do you carry a warning card?	❑	❑	
Do you ever get cold sores?	❑	❑	
Do you smoke now or previously? If so, how many per week?	❑	❑	
Do you drink alcohol? If so, how many units per week?	❑	❑	
Do you have or are you being treated for cancer?	❑	❑	
Do you suffer from any infectious diseases, including tuberculosis?	❑	❑	
Are you taking warfarin or other blood thinning medication?	❑	❑	
Are you HIV positive?	❑	❑	
Are you pregnant?	❑	❑	
Are there other health problems the dentist should know about?	❑	❑	

Completed and signed by: **Date:**

Rechecked (sign/date)				