Confidential Medical History Form

THE PARADE DENTAL

Title:	Name:	
DOB:	Occupation:	
Address Postcode:		
Home Tel No.	Mobile No.	Work No.
E-mail Address:		
How long since you last received dental treatment?		
Are you pregnant/possibly pregnant?	Yes/No	

Doctor's Details	In event of emergency, please contact
Name	Name
Address	Tel No.
	Relationship to you

Are you:	Yes	No	Give details and list medications
Receiving treatment from a doctor, hospital or clinic?			
Taking any medicines (Tablets, Injections, Inhalers, Bisphosphonates)?			
Taking or have you taken steroids in the last two years?			
Allergic to any medicines, foods or materials?			
Have you:	**Yes**	**No**	**Give details and list medications**
Had rheumatic fever or chorea (St Vitus Dance)? Heart murmur or heart problem?			
Angina, Blood pressure, Heart attack, Stroke?			
A pacemaker, or have you had any form of heart surgery?			
Asthma, Bronchitis or other chest condition?			
Hay fever, eczema, or any other allergy?			
Fainting attacks, giddiness, blackouts or Epilepsy?			
Had Jaundice, Liver or Kidney disease?			
Ever had HIV, Hepatitis B or Hepatitis C?			
Have Diabetes or does anyone in your family?			
Arthritis, Bone or Joint disease?			
Bruising or persistent bleeding after injury, tooth extraction or surgery?			
Had a bad reaction to a general or local anaesthetic?			
Been hospitalised? If "yes" what for and when?			
Carry a medical warning card?			
Alcohol and Tobacco Use	**Yes**	**No**	**Number per day**
Do you currently or did you smoke tobacco products?			Now In past
How many units of alcohol do you drink? (A unit = half pint lager/single measure of spirits/single glass of wine)			Units per week
Are there any other aspects concerning your health or issues that you think the dentist should know about?			

Signature:_____ Completed by: Self/ Parent/ Guardian Date:_____