LOW GRANGE DENTAL PRACTICE

CONFIDENTIAL MEDICAL HISTORY RECORD

PLEASE FILL OUT ACCURATELY AS FAILURE TO DSICLOSE INFORMATION COULD AFFECT YOUR HEALTH OR THE HEALTH OF SOMEONE ELSE

TITLE: MR/MRS/MISS/MS **FULL NAME:**

DATE OF BIRTH: **MALE/FEMALE**

ADDRESS: **TEL NO:**

MOBILE: **WORKS NO:**

EMERGENCY CONTACT NO AND NAME OF PERSON:

EXPECTANT MOTHER: YES/NO

HOW LONG SINCE LAST RECEIVED DENTAL TREATMENT?

DO YOUR GUMS EVER BLEED? YES/NO

DO YOU HAVE ANY PARTICULAR CONCERNS WITH YOUR MOUTH AT THE MOMENT? IF YES, WHAT:

WHY DID YOU MOVE/CHANGE FROM YOUR LAST DENTIST:

DOCTOR'S NAME AND ADDRESS:

ARE YOU	**YES**	**NO**	**DETAILS**
Attending or receiving treatment from a doctor, hospital, clinic or specialist?	( )	( )	
Taking medication from your doctor? (tablets, creams, ointments, injections)	( )	( )	
Are you or have you taken steroids in the last two years?	( )	( )	
Allergic to any medicines, foods or materials?	( )	( )	
HAVE YOU			
Had jaundice, liver, kidney disease or Hepatitis?	( )	( )	
Ever been told you have a heart murmur or heart problems, angina, blood pressure or attack?	( )	( )	
Had any blood tests, inoculations etc (excluding holiday and childhood)	( )	( )	

	YES	NO	DETAILS
Ever had your blood refused by the Blood Transfusion Service?	( )	( )	
Had a bad reaction to general or local anaesthetic?	( )	( )	
Been hospitalised? If yes, what for and when?	( )	( )	
<u>DO YOU</u>			
Have arthritis?	( )	( )	
Have a pacemaker or had any form of heart surgery?	( )	( )	
Suffer from hay fever, eczema, or have any other allergy?	( )	( )	
Suffer from bronchitis, asthma or any other chest infections?	( )	( )	
Have fainting attacks, giddiness, blackouts or epilepsy?	( )	( )	
Have diabetes or does anyone in your family? If so, who?	( )	( )	
Bruise easily, or following teeth extraction, surgery or injury, have you or your family bled so as to cause you to be worried?	( )	( )	
Carry a medical warning card?	( )	( )	
<u>DO YOU</u>			
Smoke? If so, how many?	( )	( )	
Drink alcohol? If so, how much?	( )	( )	
Drink fizzy drinks? If so, how much?	( )	( )	
Have any members of your blood family lost their teeth early through gum problems?	( )	( )	
Are there any other aspects of your health that you think the dentist should be aware of?	( )	( )	

COMPLETED BY: Self/Guardian SIGNATURE …… DATE ……..

PLEASE GIVE NAME AND RELATIONSHIP IF FILLING THIS OUT FOR SOMEONE ELSE

NAME ……..…… RELATIONSHIP ……..……