Confidential Medical History

Full name _____ DOB _____

Doctor's surgery _____

Like all dentists we ask for information regarding your general health to help us treat you safely. Please complete this form and sign. All information will be kept strictly confidential

Are you under medical care or taking any prescribed or self-prescribed medication? ☐ Yes ☐ No

Please list any medications here.

Have you been prescribed Steroids in the last year? ☐ Yes ☐ No

Have you ever been prescribed Bisphosphonates (*bone strengthening drugs*) **orally or intravenously?** ☐ Yes ☐ No

Do you have any Allergies? If so, please specify. _____ ☐ Yes ☐ No

Have you had any of the following? (please✓ all that apply) ***Please give details***

- ☐ Joint replacement or other implant _____
- ☐ Congenital heart lesion/pacemaker _____
- ☐ Jaundice, hepatitis, liver, kidney disease _____
- ☐ Heart condition/angina _____
- ☐ Infectious diseases _____
- ☐ High or low blood pressure or Stroke _____
- ☐ Bronchitis, asthma, chest conditions _____
- ☐ Prolonged bleeding/bruising problems _____
- ☐ Diabetes _____
- ☐ A medical warning card _____
- ☐ Epilepsy fits, fainting attacks _____
- ☐ Arthritis _____
- ☐ Hay Fever or Eczema _____
- ☐ Any other serious illness _____
- ☐ Blood refused when tried to donate _____

Have you had any ill effects from any of the following? ***(please tick all that apply)***

- ☐ Antibiotics ☐ Local or general anaesthetic ☐ Dental treatment
- ☐ Do you think you *may* be pregnant? If so when is the expected delivery date? _____
- ☐ Do you have problems lying flat?
- ☐ Have you ever had an operation? (please specify) ._____
- ☐ Have you ever had a close relative with CJD? (please specify) ._____

Do you smoke? ☐ Yes ☐ No If yes, how many: a day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many units a week? _____

Completed by ☐ Self ☐ Parent ☐ Guardian

Signature (Patient)	Date	Signature (Dentist)	Date