CONFIDENTIAL MEDICAL HISTORY FORM

To obtain best and safest treatment, your Sedationist needs to know of any problems which may affect your treatment.

TITLE:	NAME:	D.O.B.	M/F
ADDRESS:			
EMAIL:			
TEL /HOME/:	MOBILE:	OCCUPATION:	
PREFFERED WAY OF CONTACT:	NEXT OF KIN (NAME &PHONE No):		
EXPECTANT MOTHER: Y/N	HOW LONG SINCE LAST RECEIVED DENTAL TREATMENT:		
YOUR GP'S NAME AND ADDRESS:			

		YES	NO	DETAILS
1	ARE YOU Attending or receiving treatment from doctor, hospital, clinic or specialist?			
2	Taking any medicines from your doctor? (tablets, creams, injections, other)			
3	Taking or taken steroids in the last two years?			
4	Allergic to any medicines, foods or materials?			
1	HAVE YOU Had Rheumatic fever or Chorea ?			
2	Had jaundice, liver, kidney disease or hepatitis?			
3	Ever been told you have a heart murmur or heart problem, angina, blood pressure, heart attack?			
4	Had any infectious diseases (including Hepatitis & HIV)?			
5	Had a bad reaction to a general or local anaesthetic?			
6	Been hospitalised? If YES what for and when?			
1	DO YOU Have a hip replacement?			
2	Have a pacemaker, or have you had any form of heart surgery?			
3	Suffer from hay fever, eczema or any other allergy?			
4	Suffer from bronchitis, asthma or any other chest condition?			
5	Have fainting attack, giddiness, blackouts or epilepsy?			
6	Do you or any member of your family suffer from diabetes?			

7	Bruise easily or following a tooth extraction, surgery or injury have you or your family bled so as to cause you to be worried?			
8	Carry a warning card?			
9	Ever get cold sores?			
10	How many units of alcohol do you drink per week?			
11	Do you smoke any tobacco products now (did you in the past?) If yes, how many per day?			
Are there any other aspects concerning your health that you think the dentist should know about?				

I understand that my dentist/sedationist does not have to treat me if (a) Behaviour is aggressive or abusive (b) there is an irrevocable breakdown in the professional relationship. The above information is held in accordance with the data protection act 1998.

Completed by: Self/ Patient / Guardian:

Date......................................: Signature...

Have there been any changes in your health, medicines, injections or tablets since your last course or treatment?

MEDICAL LIST UPDATE: