Derwent Dental Care

CONFIDENTIAL MEDICAL HISTORY FORM

Title: Name: Dob: M / F				
Address:				
Email:				
Tel/ Home : Mobile : Work:				
GP Name, Address and Contact number:				
Emergency Contact Details and Number:				
Please answer the following questions with 'yes' or 'no'. If you answer yes please provide additional details.				
		Y	N	Details
	Are you likely to be pregnant			
	Are you currently receiving treatment from, doctor, hospital, clinic or specialist?			
	Are you taking any prescribed medicines? If so please list them – Please give details of what they are treating.			
	Are you Allergic to any drugs or other substance including latex? (Please state what)			
	Are you addicted to drugs or alcohol?			
	Have you ever had a heart problem, angina, high or low blood pressure, suffered a heart attack, stroke or Rheumatic fever?			
	Have you ever had Jaundice, hepatitis, liver problems or Kidney disease or organ transplant?			
	Have you ever had asthma, serious chest infection, disease or condition?			
	Have you had any recent blood tests or blood – related diseases?			
	Have you ever had your blood refused for blood transfusion?			
	Have you ever had post-operative bleeding or do you bruise or bleed excessively?			
	Have you ever had a bad reaction to local or general anaesthetic?			
	Have you ever had an operation or hospital treatment?			

Derwent Dental Care

	Have you ever had treatment for osteoporosis or any other bone condition by tablet or injection?			
	Do you suffer from arthritis?			
	Do you have a pacemaker?			
	Do you ever have fainting attacks, giddiness or epilepsy?			
	Do you or anyone in your family have diabetes?			
	Do you ever get cold sores?			
	Do you carry a warning card?			
	Do you take steroids (past or present)?			
	Do you Smoke? (If yes how many per day?)			
	Do you drink alcohol? (How many units per week?)			
	Do you have any reason to think your immunity could be suppressed?			
	Are there any other aspects concerning your health that you think we should know about?			

Please note the weight limit for our dental chairs is139kg/ 22stone.
For health and safety reasons,
If you think that your weight exceeds this then please inform a member of staff.

Signed by: Patient, Parent / Guardian……Date……..