Confidential Medical History Form

Dental Care Group

Welcome to Dental Care Group. You will shortly be going through to see your dentist. Before you do, could you take a few moments to **answer the questions on BOTH SIDES of this form** it will help us to tailor our services to your requirements. All information will be kept strictly confidential by the people caring for you.

Your Full Name:					
Title:		Date of Birth:		Sex:	Male / Female
Home Address:					
				Post Code:	
Home Tel:		Mobile Tel:			
Work Tel:		Email Address:			
Preferred method for contact:		Occupation:			
Medical Doctor's Name:		Med. Doctor's Tel:			
Medical Doctor's Address:					
When did you last receive dental treatment?					
Previous Dentist Details					
How did you hear about us?					

Are You?	Yes	No	Please provide as much detail as possible if you tick "Yes"
Attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Taking or have taken steroids in the last 2 years?			
Carrying a medical warning card?			
Are you taking any blood-thinning medication such as Warfarin, Aspirin or Clopidogrel, Dabigatran? Please specify and give your most recent INR if applicable.			
Taking Bisphosphonates or have you in the past 10 years (e.g Alendronic Acid/ Risedronate/Etidronate)			
Wearing a Pacemaker?			

Do you suffer from?	Yes	No	Please provide as much detail as possible if you tick "Yes"
Allergies to any medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods (e.g nuts/shellfish)			
Hay Fever or Eczema?			
Bronchitis, emphysema, COPD other chest / lung condition?			
Asthma? How Severe? Do you use inhalers?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart conditions, angina, stroke? Heart surgery?			
Diabetes? Type 1 or Type 2? (medications taken?)			
Blood Pressure? Taking any Blood Pressure Medication			
Arthritis or other bone/joint disease?			
Thyroid Problems? (over or under active)			
Liver or Kidney Disease? Or had Jaundice?			
Any infectious diseases (e.g HIV, Hepatitis B, C, or D, HPV)?			

PLEASE TURN OVER

Dental Care Group

Have you ever had?	Yes	No	
Osteoporosis?			
Radiotherapy or Chemotherapy?			
A bad reaction to Local or General Anaesthetic?			
Cold sores?			
Hayfever / Eczema or other allergies?			

Alcohol Consumption

How many units of alcohol do you drink per week? (A unit is a half pint of lager, a single measure of spirits or a single glass of wine/aperitif.)	

Smoking / Tobacco	Yes	No	In Past	Number a Day	Years Smoked?
Do you smoke any tobacco products now or in the past?					
Do you chew tobacco, paan, arecanut, supari, use gutkha (or did you in the past)? How many times a day?					

Women Only	Yes	No	In Past	
Is there a possibility you may be pregnant?				
Have you had a baby in the last 12 months?				

If you could change anything about your smile...

What would it be?

We occasionally send important information, newsletters and details about our services by email, please tick to confirm you are happy for us to send you this important information.☐

Name:_____ Signature:_____ Date:_____
Patient / Parent / Guardian (delete as applicable)

List of Prescribed Medications (please attach a prescription list if necessary)

Medication Name	Dose	Number of times a day	What is the medication for?