Confidential Patient History Form

It is important for us to have up to date medical history for all our patients. Please take time to complete the form and answer the following questions. Providing this information helps us treat our patients safely. All information provided will be kept strictly confidential.

Surname: .... First name(s): ....

Date of Birth: .... Sex: .... Title: ....

Address: ....
....
....
....
....

Telephones Home: ....
Work: ....
Mobile: ....
(Please highlight preferred contact number)

Occupation: ....
Doctors Name: ....
Doctors Address: ....
....

Post Code: ....

E-Mail: ....

How did you find out about us (New Patients) ....

Name of previous Dentist ....

Do you have, or have you suffered from any of the following? (Please tick Yes or No)

<u>Please list medication/other details:</u>

Condition	Yes / No
Rheumatic Fever	Yes...../ No.....
Any heart condition	Yes...../ No.....
Diabetes	Yes...../ No.....
Epilepsy	Yes...../ No.....
Asthma or Bronchitis	Yes...../ No.....
Liver disease	Yes...../ No.....
Excessive bleeding	Yes...../ No.....
High blood pressure	Yes...../ No.....
Any serious illness	Yes...../ No.....
Any allergies including medicines	Yes...../ No.....
Had any surgical operations	Yes...../ No.....
Bruising or persistent bleeding	Yes...../ No.....
Any infectious diseases including HIV and Hepatitis	Yes...../ No.....

Do you smoke Yes...../ No..... If yes, how many per day? ....
How many units of alcohol do you drink per week? ....
(1 unit =1 glass wine, ½ pint beer or lager or 1 measure of spirit)
Do you chew any form of tobacco? (Betelnut, Paan)? Yes...../ No.....

Are you happy with the appearance of your teeth? Yes...../ No.....
If no, what would you like to change...

Would you consider yourself a nervous patient? Yes...../ No.....

Could all ladies please complete the following section

Do you take the oral contraceptive pill? Yes...../ No.....
Are you pregnant? Yes...../ No.....

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

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