PATIENTS DENTAL HISTORY AND INFORMATION SHEET

I understand that any information supplied will be treated as **STRICTLY CONFIDENTIAL**

FULL NAME (MR/MRS/MISS/MS).....DATE OF BIRTH.....

ADDRESS.....

.....POSTCODE.....

TEL NO (HOME).....MOBILE.....OCCUPATION.....

DOCTORS NAME.....DOCTORS TEL NO.....

PLEASE ANSWER THE FOLLOWING QUESTIONS CAREFULLY TO ENABLE YOUR DENTIST TO GIVE THE BEST POSSIBLE TREATMENT.

1. When was your last visit to the dentist.....

2. Are you under the care of a doctor at present ?.....If yes, for what purpose.....

3. Are you taking any medication or drugs now, ie medicine, pills, tablets, ointments, injection etc either from your doctor or of your own accord ?.....If yes, please state.....

4. Are you allergic to Penicillin, antibiotics, food or other substances ?.....If yes, please state.....

5. Have you had any serious childhood illness ?.....If yes, please state.....

6. Do you have any of the following ? (Please delete as applicable)

Heart/Blood Pressure Trouble	Yes/No	Brain Surgery or Growth Hormones (B4 1980)	Yes/No
Hay Fever or Eczema	Yes/No	Rheumatic Fever orChorea (St Vitus Dance)	Yes/No
Heart Murmur, Heart Surgery or Stroke	Yes/No	Diabetes	Yes/No
Asthma, Bronchitis or Chest Troubles	Yes/No	Liver/Kidney Trouble	Yes/No
Infectious diseases (including HIV or hepatitis)	Yes/No	Fainting, Giddiness or Blackouts	Yes/No
Arthritis	Yes/No	Ear or Eye Problems	Yes/No

7. After an extraction, surgery or injury have you or any member of your family bled for such a time as to cause concern ?.....

8. After a general/local anaesthetic (including dental gas or injection in the arm) have you had an abnormal reaction ?.....

9. Has your doctor issued you with a warning card ?.....

10. Are you pregnant ?.....If yes, when are you expecting.....

11. Is there any other information concerning your health you should bring to the attention of your dentist, such as self prescribed medicines.....

12. Do you smoke.....If yes how many per day.....

12. How much alcohol do you drink in a week (1 unit being half a pint of beer or a small glass of wine) .....

SIGNED BY.....DATE.....

DO YOU WISH TO BE TREATED PRIVATELY OR UNDER THE NATIONAL HEALTH SERVICE ?.....

Medical History Update

Date	No Change	Any Changes	Patient Initials
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....