Confidential
Medical History Form

Charlbury Dental Practice

We ask you for information about your general health to help us treat you safely. Please write your contact details below, answer the health questions and then sign the form on the back page. We will use this form at later visits to discuss any change in your general health. All information will be kept strictly confidential by the people caring for you.

Title:	**Last name:**		
	First name:		
	Date of birth: / /	**Sex:** Male ☐	Female ☐
	School attended:		
Address:			
	Postcode:		
Tel no (home):			
Mobile no:	**Work no:**		
Email:			
Are you happy for us to contact you by:	**Text** ☐	**Phone** ☐	**Email** ☐ *(please tick all that apply)*
Please check box if you DO NOT give permission for messages regarding your appointments to be left on your landline answer phone, or relayed on the phone to a family member ☐			
Occupation:			

In the event of an emergency, please contact:

Name:	
Tel no:	**Relationship to you:**

Doctor's details:

Doctor's name:	**Tel no:**
Address:	
	Postcode:

Are you currently	Yes / No	Give details
Receiving treatment from a doctor, hospital or clinic?		
Taking any prescribed medicines (eg tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?		
Carrying a medical warning card?		
Pregnant or possibly pregnant?		

Have you ever suffered from	Yes / No	Give details
Allergies to medicines (e.g. Penicillin) substances (e.g. Latex/rubber) or foods?		
Bronchitis, asthma or other chest condition?		
Fainting attacks, giddiness, blackouts or epilepsy?		
Heart problems, angina, blood pressure problems or stroke? Diabetes (or does anyone in your family)?		
Bone or joint disease?		
Bruising or persistent bleeding following injury, tooth extraction or surgery?		
Liver disease(eg jaundice, Hepatitis) or kidney problems.		

Have you ever had	Yes / No	Give details
Any other serious illness or infectious disease?		
Blood refused by the Blood Transfusion Service?		
A bad reaction to general or local anaesthetic?		
Treatment that required you to be in hospital?		
Heart surgery?		

Alcohol

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

_____**units per day/week**

Smoking	Yes / No / In the past
Do you smoke any tobacco products now (or did you in the past?)	

_____**times per day**

Please give any other details which your dentist might need to know about, such as self-prescribed medicines (eg aspirin). Please also tell us of any disability you may have and tell us of ways in which we can assist you, with regard to your disability.

Completed by (please tick) **self** ☐ **parent** ☐ **guardian** ☐

Patient signature _____ **Date** _____

Dentist signature _____ **Date** _____

Medical history update

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

Date	Any changes	List changes below	Patients initials