Confidential medical history form

This information is CONFIDENTIAL and very important. We use it to assess the risks with your treatment, evaluate possible side effects between drugs, to give you the correct postoperative advice or in case you would have a dental or medical emergency in the surgery. Please fill in this form as completely and accurately as possible. Present and past medical conditions, medications and other forms of treatment are relevant. Please do not forget over the counter drugs, recreational drugs and herbal remedies. We need to know this information in order to make your treatment as safe as possible. Please write clearly using capital letters. If you need more room to answer any questions, please use space at the end of the form or use a separate sheet of paper. If you do not understand any questions please ask your dental practitioner who will be happy to help.

Title:		Surname:		First name:		Middle name:	

Date of birth:		Gender:	Male:		Female:	
Occupation:						

This information is needed in order to assess your risk of developing dental or medical conditions of importance for our treatment options and prevention. For example: Chefs/kitchen staff/wine tasters are more prone to dental decay or erosion due to the fact that they have to taste food or drink often. Knowing this will allow us to set up individualised prevention programmes. Another example: Ware house worker. Static repetitive jobs may lead to muscle tensions and frequent headaches. Knowing this will allow us to correctly diagnose and treat tension headaches.

Home address			
Street name		Town/City/Locality:	
County:		Postcode	
Home Phone:		Work Phone:	
Mobile:		Email:	

Address and contact details of patient's GP		Name of surgery:	
Street name		Town/City/Locality:	
County:		Postcode	
Telephone:		Email:	

Next of kin details if we need to contact anybody in case of a medical emergency:			
Name:		Contact number:	

In case I need to make or change appointments and I cannot do this personally, I allow the following person/persons to make or change appointments on my behalf or to receive information of my appointments. I understand that no information on this medical history form will be discussed with the named person/persons.

Name of persons allowed to make or change appointments on my behalf:	Signature to confirm that named person/s are allowed to make or change appointments on my behalf
....	
....	Signed:
....	....

Are you in good health generally?	Yes	No	If Not, please fill out the relevant boxes below.
For women only: Are you pregnant or are you trying to conceive?			

Have you experienced or are you • presently being treated, • under consideration of future treatment or • have already had treatment for any of the conditions stated below? Please read all the options before you start filling in the form. It may save you some time and double entries.	Yes	No	Do you take any medication or do you undergo any other treatment for the stated condition? Please give details. If you take medication for the condition, please give correct names, doses and how often you take any drugs for the stated condition. If you have a medical condition but do not take any medication or do not undergo any treatment for it, then tick "Yes" and specify " No treatment" or "Treated by diet" or "Treated by exercise" or "Physiotherapy", etc as appropriate.
1. High blood pressure? Medication?			
2. High cholesterol levels? Medication?			
3. Chest Pain (Angina)?			
4. Swollen ankles?			
5. Shortness of breath?			
6. Heart disease?			
7. Heart attack, heart defect?			
8. Heart murmurs?			
9. Rheumatic fever?			
10. Prosthetic heart valve/s?			
11. Carotid or coronary artery stents? If yes, when?			
12. Hardening of the arteries, atherosclerosis?			
13. Stroke?			
14. Recent weight loss, fever night sweats?			
15. Persistent cough, coughing up blood?			
16. Bleeding problems, bruising easily?			
17. Sinus problems?			
18. Difficulty swallowing?			
19. Diarrhoea, constipation, blood in stools?			
20. Frequent vomiting, nausea?			
21. Difficulty urinating, blood in urine?			
22. Dizziness?			
23. Ringing in ears, tinnitus?			
24. Headaches?			
25. Fainting?			
26. Blurred vision?			
27. Seizures, epilepsy?			
28. Excessive and frequent thirst?			
29. Frequent urination?			
30. Dry mouth?			
31. Jaundice?			
32. Joint pain, stiffness of joints?			
33. Dry eyes?			
34. Asthma, TB, emphysema, other lung disease?			
35. Hepatitis, other liver disease?			
36. Stomach problems, ulcers?			
37. Allergies to anything? Drugs/medications, foods, latex, metals, sticky plasters etc?			
38. Arthritis, rheumatoid arthritis?			
39. Inflammatory or Autoimmune diseases, SLE, Sjogren's syndrome, Chrohn's disease etc			
40. Tumours, cancer?			

41. Eye diseases?			
42. Skin diseases?			
43. Anaemia?			
44. Kidney or bladder disease?			
45. Thyroid disease?			
46. Adrenal disease?			
47. Any other endocrine disease? Problems with hormones?			
48. Diabetes?			
49. AIDS, HIV?			
50. Sexually transmitted disease? HPV, Human Papilloma virus is linked to both cervical cancer in women and oral cancer in both sexes.			
51. Family history of diabetes, heart problems, tumours?			
52. Psychiatric disorders? Depression, bipolar, psychoses etc?			
53. Radiation treatment now or in the past?			
54. Chemotherapy now or in the past?			
55. Artificial joint/s?			
56. Hospitalisation?			
57. Blood transfusions?			
58. Brain or spinal damage?			
59. Are you taking recreational drugs? All is confidential!			
60. Natural remedies or over the counter medicines?			
61. Tobacco in any form? How many cigarettes/day?			
62. Alcohol intake. Units/week. One pint of beer 4.2% ABV =2.4 units. One glass of wine of 175ml at 12% strength =2.1 Units			
Do you have any **other conditions** or do you take **any medication not mentioned above**?			
63.			
64.			
65.			

Other issues: Dental anxiety, Gagging in dental chair, Difficulty in opening mouth, Jaw joint problems, Frequent headaches, Present dental pain, Frequent mouth ulcers, Dry mouth, Bad breath, Sensitive teeth, Tooth grinding etc.

To the best of my knowledge I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication.

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

I give permission to:

- my treating dentist or
- person appointed by my treating dentist

to discuss my medical history with my GP, Hospital consultant, Ambulance staff and any relevant medically trained person involved in my dental or medical treatment.

Signature of confirmation: ....

LIGHTHOUSE DENTAL PRACTICE

Changes to my medical history			
Date:	No changes		Signature:
	Changes		
Date:	No changes		Signature:
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