CASTLETONDENTAL

CONFIDENTIAL MEDICAL HISTORY FORM

To obtain the best and safest treatment, your dentist needs to know of any problems which may affect your treatment.

PERSONAL DETAILS

TITLE | FIRST NAME | SURNAME

ADDRESS

TEL. NO. HOME | WORK | MOBILE

EMAIL | OCCUPATION

D.O.B | NEXT OF KIN | CONTACT NO.

DOCTOR'S NAME | ADDRESS

ARE YOU:

(More space on reverse)

Attending or receiving treatment from a doctor, hospital or clinic?	YES ☐	NO ☐	DETAILS
Taking any medicines from your doctor?	YES ☐	NO ☐	DETAILS
Taking or have taken steroids in the last two years?	YES ☐	NO ☐	DETAILS
Allergic to any medicine or materials?	YES ☐	NO ☐	DETAILS
An expectant mother? If yes when is your due date?	YES ☐	NO ☐	DETAILS

HAVE YOU:

Had Rheumatic fever, Chorea or St Vitus Dance?	YES ☐	NO ☐	DETAILS
Had Jaundice, Liver, Kidney disease or Hepatitis?	YES ☐	NO ☐	DETAILS
Ever been told you have a Heart murmur or Heart problem, Angina, Blood pressure problems, or had a Heart attack?	YES ☐	NO ☐	DETAILS
Had any blood test, inoculations recently?	YES ☐	NO ☐	DETAILS
Ever had your blood refused by the Blood Transfusion Service?	YES ☐	NO ☐	DETAILS
Had a bad reaction to a general or local anaesthetic?	YES ☐	NO ☐	DETAILS
Had a joint replacement?	YES ☐	NO ☐	DETAILS
Been hospitalised within the last 5 years?	YES ☐	NO ☐	DETAILS

DO YOU:

Have Arthritis?	YES ☐	NO ☐	DETAILS
Have a Pacemaker, or have you had any form of heart surgery?	YES ☐	NO ☐	DETAILS
Suffer from Hayfever, Eczema or any other allergy?	YES ☐	NO ☐	DETAILS
Suffer from Bronchitis, Asthma or any other chest condition?	YES ☐	NO ☐	DETAILS
Have fainting attacks, giddiness, blackouts or Epilepsy?	YES ☐	NO ☐	DETAILS
Have Diabetes or does anyone in your family?	YES ☐	NO ☐	DETAILS
Bruise easily or bleed following a tooth extraction, surgery or injury?	YES ☐	NO ☐	DETAILS
Carry a warning card?	YES ☐	NO ☐	DETAILS

Are there any aspects concerning your health that you think the Dentist should know about?

How did you hear of the practice?

Completed by: Self/Parent/Guardian

Name | Signature | Date

FURTHER DETAILS

MEDICATION

MEDICAL HISTORY UPDATE

Please check your medical history carefully and amend any changes below. Thank you.

DATE	UPDATE	SIGNATURE