CONFIDENTIAL MEDICAL HISTORY FORM

BRIDGE DENTAL PRACTICE

We ask you for information about general health to help us treat you safely. Please write your contact details below in block capitals, answer the health questions and then sign the form on the reverse. 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.

Surname: First name/s Title:

Sex: Male ☐ Female ☐ Date of birth:

Address:

Postcode:

Telephone – Home: Mobile:

Email: Occupation:

Next of kin: Next of kin contact number:

Doctor's name:

Doctor's address:

Postcode: Doctor's telephone:

How long is it since you last received dental treatment?

Please answer all the below questions by ticking 'yes' or 'no'. If you answer 'yes' to any questions please provide additional details in the space available. All information provided will be kept strictly confidential.

1. Are you currently:	**Yes**	**No**	**Details**
Attending or receiving treatment from a doctor, hospital clinic or specialist?	☐	☐	_____
Taking any prescribed medicines from your doctor (e.g. tablets, ointments, injections or inhalers)?	☐	☐	_____
Taking or have taken steroids in the last two years?	☐	☐	_____
Pregnant or possibly pregnant?	☐	☐	_____
Taking bisphosphonates (medication used for hormone replacement therapy, menopause and osteoporosis)?	☐	☐	_____
Taking the contraceptive pill or hormone replacement therapy?	☐	☐	_____

2. Have you ever had:	**Yes**	**No**	**Details**
Allergies to medicines, foods or materials (e.g. latex/rubber)?	☐	☐	_____
Jaundice, liver/kidney disease or hepatitis?	☐	☐	_____
A heart murmur or heart problem, angina, blood pressure or had a heart attack?	☐	☐	_____
Any blood tests or inoculations?	☐	☐	_____
Your blood refused by a blood transfusion centre?	☐	☐	_____
A bad reaction to a general or local anaesthetic?	☐	☐	_____
Bone or joint disease?	☐	☐	_____

Please continue overleaf.

2. *Continued*	Yes	No	Details
Brain Surgery?	☐	☐	_____
Growth hormone treatment before the mid 1980's?	☐	☐	_____
Been hospitalised? If yes what for and when?	☐	☐	_____
Any previous skin rejuvenation treatments?	☐	☐	_____

3. Do you:	Yes	No	Details
Have a close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease?	☐	☐	_____
Have arthritis?	☐	☐	_____
Have a pacemaker or have you had any form or heart surgery?	☐	☐	_____
Suffer from asthma or other chest conditions?	☐	☐	_____
Have any allergies to any drugs or chemicals?	☐	☐	_____
Have fainting attacks, giddiness, blackouts or epilepsy?	☐	☐	_____
Have diabetes or does anyone in your family have diabetes?	☐	☐	_____
(Or does anyone in your family) bruise easily or bleed heavily as to cause worry following a tooth extraction, injury or surgery?	☐	☐	_____
Carry a medical warning card?	☐	☐	_____
Ever get cold sores?	☐	☐	_____
Have any infectious diseases (including HIV or hepatitis)?	☐	☐	_____
Suffer from any other serious illness?	☐	☐	_____
Suffer from sleep apnoea?	☐	☐	_____

4. Alcohol and tobacco usage:

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

Do you smoke any tobacco products now (or did you in the past)? No ☐ Yes ☐ In the past __ times per day

Do you chew tobacco? No ☐ Yes ☐ In the past __ times per day

5. Further medical information:

Please give any other details which your dentist night need to know about, such as self-prescribed medicines (e.g. aspirin).

_____

Completed by: (please tick)
☐ Self ☐ Parent ☐ Guardian

Signature: Date:

From time to time, Bridge Dental Practice may have information, offers or promotions that we would like to contact you about. If you are happy to be contacted, please indicate you would prefer to hear from us (you can tick more than one box):

☐ Mail ☐ Phone ☐ Email ☐ Text/SMS

You will only ever receive communication from Bridge Dental Practice.

Medical history update

Please check that the health information on this form is still correct (including information on tobacco use and alcohol consumption). If any details have changed, please amend as necessary or note any changes below.

Date	No change	List any changes below	Patient's initials