Confidential Medical History Form

To enable us to treat you safely we need to ask you for some information about your general health. All information will be kept strictly confidential.

Crofts Dental Practice

Name:	DOB:
Address:	
Contact:	
Email:	
Occupation:	

ARE YOU	YES	NO	DESCRIPTION
1. Pregnant?			
2. Attending or receiving treatment from a doctor, hospital, clinic or specialist?			
3. Taking any medicines from your doctor?			
4. Taking or have you taken steroids in the last two years?			
5. Allergic to any medicine (eg antibiotics), materials (eg latex/rubber) or foods?			
HAVE YOU			
1. Had rheumatic fever or chorea (St Vitus Dance)?			
2. Had jaundice, liver, kidney disease or hepatitis?			
3. Ever had blood refused by The Blood Transfusion Service?			
4. Ever been told you have a heart murmur or heart problem, angina, blood pressure or heart attack?			
5. Ever had a bad reaction to a general or local anaesthetic?			
6. Had a joint replacement or other implant?			
7. Been hospitalised? If 'YES' for what and when?			
DO YOU			
1. Have arthritis?			
2. Have a pacemaker?			
3. Suffer from hay fever, eczema or any other allergy?			
4. Suffer from bronchitis, asthma or any other chest condition?			
5. Have fainting attacks, giddiness, blackouts or epilepsy?			
6. Have diabetes?			
7. Bruise easily or persistently bleed following injury, tooth extraction or surgery?			
8. Suffer from any infectious diseases (including H.I.V.)?			
9. Carry a warning card?			
10. Smoke? If yes, approximately how many each week?			
11. Drink alcohol? If yes, approximately how many units each week?			

Please list any medication, and write down any other medical information that may be useful to give you the possible care.

Signed by Self / Parent / Guardian ..... Date .....

Reception 01992 574 004 Out of Hours/Emergency 01992 800 947 Email enquiries@croftsdental.co.uk Web www.croftsdental.co.uk

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