

# **CAMBERWELL DENTAL CARE CONFIDENTIAL MEDICAL HISTORY** F

To help us treat you safely it is important that we ask you the following questions about your general health. Please answer all the questions by ticking the appropriate box and if necessary add any additional details. All information provide will b e kept strictly confidential

**Title** \_\_\_\_\_ **Surname** \_\_\_\_\_ **Firstname** \_\_\_\_\_

**Sex**      **Male**                      **Female**

**Date of birth**      **day** \_\_\_\_\_ **month** \_\_\_\_\_ **year** \_\_\_\_\_

**Your Address** \_\_\_\_\_ **postcode** \_\_\_\_\_

**Telephone**   **home** \_\_\_\_\_ **work** \_\_\_\_\_ **mobile** \_\_\_\_\_

**Your Previous Address** \_\_\_\_\_ **postcode** \_\_\_\_\_

**NHS Number** \_\_\_\_\_ **Occupation** \_\_\_\_\_ **email-address** \_\_\_\_\_

**Your GP Surgery name and address** \_\_\_\_\_

**Telephone number** \_\_\_\_\_

**Your Previous Dentist name and address** \_\_\_\_\_

**Telephone number** \_\_\_\_\_

**When was your last visit to a dental surgery?** \_\_\_\_\_

	YES	NO	DETAILS
1. Are you receiving treatment from a doctor, hospital or clinic?			
2. Are you taking any prescribed medicines (e.g. Tablets, ointments, injection or inhalers, including contraceptives and hormone replacement therapy)?			
3. Do you carry a medical warning card?			
4. Any allergies to medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods?			
5. Hay fever or eczema?			
6. Bronchitis, asthma or other chest conditions?			
7. Fainting attacks, giddiness, blackouts, epilepsy?			
8. Heart problems, angina, blood pressure problems, or stroke?			
9. Are you diabetic?			
10. If yes to diabetic, Is it well controlled?			
11. Do you suffer from arthritis?			
12. Bruising or persistent bleeding following an injury, tooth extraction or, surgery?			
13. Infectious diseases including HIV and Hepatitis?			
14. Ever had Rheumatic fever or chorea?			
15. Ever had liver disease (e.g. jaundice, hepatitis) or kidney disease?			
16. Ever had other serious illness or infection disease?			
17. Ever has Blood refused by the blood transfusion service?			
18. Ever had a bad reaction to general or local anaesthetic?			
19. Ever had a joint replacement or other implant?			
20. Ever had a treatment that required you to be in hospital?			
21. Ever had Heart surgery?			
22. Ever had Brain surgery?			
23. Growth hormone treatment before 80's?			
24. A close relative with CJD (Creutzfeldt-Jakob Disease)			
25. Reflux or any eating disorders?			
26. Other information your dentist may need to know?			
27. Pregnant or possibly pregnant?			
28. Do you or have you smoke any tobacco products?			
29. Do you chew tobacco?			
30. Do you regularly drink more than 14 units of alcohol a week?			
31. Do you have a diet high in sugar?			
32. Do you drink fizzy or acidic drinks regularly?			
<b>Signature</b> _____			<b>Date</b> _____

**PLEASE TURN OVER**