CAMBERWELL DENTAL CARE CONFIDENTIAL MEDICAL HISTORY M

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 join 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. Do you or have you smoke any tobacco products?			
28. Do you chew tobacco?			
29. Do you regularly drink more than 21 units of alcohol a week?			
30. Do you have a diet high in sugar?			
31. Do you drink fizzy or acidic drinks regularly?			
Signature____			Date_________________

PLEASE TURN OVER