

CAMBERWELL DENTAL CARE CONFIDENTIAL MEDICAL HISTORY C

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 have a diet high in sugar? | | | |
| 30. Do you drink fizzy or acidic drinks regularly? | | | |
| 31. History of previous caries? | | | |
| 32. Siblings that have caries in the past 2 years? | | | |
| Signature _____ | | | Date _____ |

PLEASE TURN OVER