MEDICAL HISTORY

(Mr, Mrs, Miss, Ms, Other) Surname: _____

Forename(s): _____

Address: _____

_____Postcode_____

Mobile Number: _____

Home Number: _____

Date of Birth: _____

Occupation: _____

Doctor's Name & Address

Consent for Photos

Please note that we may take photos of some of the treatment that we perform at our practice as part of your clinical record. Please tick one of the boxes to indicate consent for these images to be taken.

- ☐ I consent to images being taken
- ☐ I do not consent to images being taken

At Alrewas Dental Practice, we take great care with all the personal data we hold, to ensure we comply with the best professional practice and with the law. For a full copy of our Data Privacy Notice please ask at reception.

Confidential Medical History Questionnaire: Please complete as fully as possible	Yes	No	Specify
1. Have you been seen by your family doctor or a medical specialist in the past year?			
2. Have you been hospitalised for serious illness or an operation in the past 3 years?			
3. Do you have a registered disability? If yes please give details:			
4. Are you carrying a medical warning card or bracelet?			
5. Have you ever had a blood transfusion?			
6. Do you suffer from Rheumatic fever/congenital heart defect/bacterial endocarditis?			
7. Do you suffer from any heart problems, angina, high blood pressure, arrhythmia or stroke?			
8. Do you suffer from jaundice, hepatitis, or other liver or gall bladder disease?			
9. Do you suffer from chest trouble, breathing difficulty, asthma, bronchitis, emphysema, bronchitis			
10. Do you have a history of excessive bleeding or blood disorders in the family?			
11. Diabetes: Type I (controlled by insulin) Type II (oral medication)?			
12. Allergy or adverse reactions to any drugs (e.g. penicillin)			
13. Allergy or adverse reaction to local or general anaesthetics?			
14. Do you suffer from panic attacks, fainting attacks, giddiness, epilepsy, blackouts or memory loss?			
15. Do you suffer from stomach or bowel trouble, hiatus hernia, acid reflux or regurgitation?			
16. Do you suffer from hay fever, eczema or contact allergy (e.g. latex or certain metals)			
17. Bone or joint disorders (e.g. osteoporosis, arthritis, Paget's disease?			
18. Are you a smoker or have you been a smoker within the last 5 years?			
19. How much do you smoke per day?			
20. How many units of alcohol do you drink per week?			
21. Have you, in the last two years, received any steroid medication?			
22. Do you take anticoagulant (blood thinning) medication?			
23. Do you take bisphosphonate medication, such as Fosamax or Actonel?			
24. Do you have any artificial prostheses, such as a heart valve or joint replacement?			
25. Do you have a pacemaker for your heart?			
26. Are you pregnant?			
27. Are you HIV positive, Hepatitis B or C positive?			
28. Do you have a close family member with inherited variant Creutzfeldt-Jakob disease?			
29. Have you been treated with growth hormone before the mid 80's or received a dura mater graft following neurosurgery?			

Please list ALL the medicines (prescribed, over the counter or self medication) you take on a regular basis, including contraceptive pills, homeopathic and herbal remedies, ointments, or recreational drugs. If possible include dosages and frequency.

Medication Name	Dosage	Taken since

Please add anything else that you feel may be of medical importance.

Signature: _____ Date: _____

Please tick Yes or No if there are any changes, make appropriate notes, then sign and date.

Changes:

- ☐ Yes
- ☐ No

Signature: _____ Date: _____

Changes:

- ☐ Yes
- ☐ No

Signature: _____ Date: _____

Changes:

- ☐ Yes
- ☐ No

Signature: _____ Date: _____

Changes:

- ☐ Yes
- ☐ No

Signature: _____ Date: _____

Changes:

- ☐ Yes
- ☐ No

Signature: _____ Date: _____