ActiveDental

Dental Prosthetics | Dentures | Implants

# Confidential Medical History Form

We ask you for information about your general health to help us treat you safely. Please write your contact details below, answer the health questions inside then sign the form. We will use this form at later visits to discuss any change in your general health. **All information will be kept strictly confidential by the people caring for you.**

| | |
|---|---|
| **Surname** | First Name(s) |
| Sex ☐ MALE ☐ FEMALE | Date of birth |
| Address | Home Phone |
| | Mobile |
| | Email |
| | Occupation |

Doctor's Name and Address:

| | |
|---|---|
| | Name & Address |
| | Phone Number |

In the event of an emergency, please contact:

| | |
|---|---|
| | Name |
| | Mobile Number |

| Are you currently... | YES | NO | Give Details |
|---|---|---|---|
| Receiving treatment from a doctor, hospital or clinic? | ☐ | ☐ | |
| Taking any prescribed medicines (eg tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)? | ☐ | ☐ | |
| Carrying a medical warning card? | ☐ | ☐ | |
| Pregnant or possibly pregnant? | ☐ | ☐ | |

| Have you ever suffered from... | YES | NO | Give Details |
|---|---|---|---|
| Allergies to medicines (eg penicillin), substances (eg latex/rubber) or foods? | ☐ | ☐ | |
| Bronchitis, asthma or other chest condition? | ☐ | ☐ | |
| Fainting attacks, giddiness, blackouts, epilepsy? | ☐ | ☐ | |
| Heart problems, angina, blood pressure problems, or stroke? | ☐ | ☐ | |
| Diabetes (or does anyone in your family)? | ☐ | ☐ | |
| Bone or joint disease? | ☐ | ☐ | |
| Bruising or persistent bleeding following injury, tooth extraction or surgery? | ☐ | ☐ | |
| Liver disease (eg jaundice, hepatitis) or kidney disease? | ☐ | ☐ | |
| Any other serious illness or infectious disease? | ☐ | ☐ | |
| Blood refused by the Blood Transfusion Service? | ☐ | ☐ | |
| A bad reaction to general or local anaesthetic? | ☐ | ☐ | |
| Treatment that required you to be in hospital? | ☐ | ☐ | |
| Heart surgery? | ☐ | ☐ | |

## Alcohol...

How many of units of alcohol do you drink per week?
(A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitif)

UNITS PER WEEK

## Tobacco use...

| | YES | NO | IN THE PAST | |
|---|---|---|---|---|
| Do you smoke any tobacco products now ? (or did you in the past) | ☐ | ☐ | ☐ | TIMES PER DAY |
| Do you chew tobacco, pan, use gutkha or supari now? (or did you in the past)? | ☐ | ☐ | ☐ | TIMES PER DAY |

## Please give any other details which your Clinical Dental Technician might need to know about, such as self-prescribed medicines (eg aspirin) or any disabilities you may have...

## Completed by...

☐ SELF ☐ PARENT ☐ GUARDIAN

| Patient's signature | Date |
|---|---|
| Clinical Dental Technician's signature | Date |

## Medical history update...

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

| DATE | NO CHANGE | LIST ANY CHANGES BELOW | PATIENT'S INITIALS |
|---|---|---|---|
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