

PT REF _____

PRIORY DENTAL CENTRE

CONFIDENTIAL MEDICAL HISTORY FORM

We need to know of any problems which may affect your treatment. Please answer below as accurately as possible.

SURNAME _____ FIRST NAME _____

TITLE _____ MALE/FEMALE _____ DATE OF BIRTH _____

HOME ADDRESS _____

POSTCODE _____

HOME TEL # _____ MOBILE # _____

WORK TEL # _____

WHEN DID YOU LAST VISIT A DENTIST? _____

NAME & ADDRESS OF DOCTOR _____

DOCTORS TEL # _____

ARE YOU	YES	NO	DETAILS
Pregnant?			
Attending or receiving treatment from a doctor, clinic, hospital or specialist?			
Taking any medicines or tablets (including creams, ointments, inhalers or contraceptive pill)?			
Being treated or have been treated with steroids in the past 2 years?			
Allergic to any medicines / tablets e.g. Penicillin?			
Allergic to any other things e.g. Iodine, Latex etc?			
Carrying a medical warning card?			

HAVE YOU EVER

Been told you have a heart complaint?			
Had rheumatic fever, heart murmur or heart valve disease in the past?			
Suffered from hepatitis or HIV?			
Suffered from liver disease e.g. jaundice?			
Had your blood refuse by a blood transfusion service?			
Had any blood pressure problems?			
Experienced excessive bleeding after a tooth extraction?			
Had a major operation? Please give details			
Had a serious illness? Please give details			
Had a bad reaction to general or local anaesthetic?			
Had radiotherapy?			
Had brain surgery?			
Received growth hormone since the mid 1980's?			
Or any family member suffered from CJD?			

DO YOU

Suffer from epilepsy?			
Suffer from eczema?			
Suffer from hay fever?			
Suffer from asthma?			
Suffer from diabetes or anyone else in your family?			
Suffer from bronchitis or any chest condition?			
Smoke? If so how many per day?			
Drink more than 21 units of alcohol per week?			

If there is any other aspect of your health that you feel may be relevant to your treatment which the dentist should be aware of, please give details;

Signature _____ **Date** _____