ACORN DENTAL SURGERY

Medical History Form

In order to provide you with the most appropriate and safest treatment, your dentist needs to know about any previous or current medical conditions since many of them can affect your dental treatment. Completion of this questionnaire will help us to help you and together we will update your records at each new course of treatment.

ALL DETAILS WILL BE STRICTLY CONFIDENTIAL

Surname: _____

Forename(s): _____ **Title:** _____

Male ☐ **Female** ☐ **Date of birth:** _____ day _____ month _____ year

Address: _____

_____

_____ **Postcode:** _____

Telephone: (Home) _____ **(Work)** _____

(Mobile) _____

Email: _____

Occupation: _____

Doctor's name: _____

Address: _____

_____

_____

Doctor's telephone number: _____

Date of last dental treatment: _____

Recommended by: _____

Questions	Yes	No	Details
ARE YOU: **1. Attending or receiving treatment from a doctor, hospital, clinic or specialist?**			
2. Taking any medicines prescribed by your doctor? (Tablets, creams, ointments, injections or inhalers, including contraceptives, or hormone replacement therapy)			
3. Allergic to penicillin or any other drug or substance?			
4. Likely to be pregnant?			
5. Carrying any medical warning card?			
HAVE YOU: **1. Ever been told that you have a heart problem, angina, high or low blood pressure, or suffered a heart attack or stroke?**			
2. Had rheumatic fever or chorea (St Vitus's Dance)			
3. Ever had liver disease (e.g. jaundice, hepatitis) or kidney disease?			
4. Ever had any serious chest conditions, e.g. bronchitis, asthma?			
5. Ever had any form of cancer?			
6. Ever had any blood tests or blood related diseases?			
7. Had any fainting attacks, giddiness, blackouts or epilepsy?			
8. Ever had any reaction to a local or general anaesthetic?			
9. Had a heart valve replaced?			
10. Ever had blood refused by the blood transfusion service?			
11. Had a joint replacement, or other organ implant?			
12. Ever been in hospital? If YES, for what and when?			

Questions	Yes	No	Details
DO YOU:			
1. Have hay fever or eczema?			
2. Have arthritis?			
3. Have a heart pacemaker?			
4. Have diabetes, or does anyone in your family have it?			
5. Bruise easily or have persistent bleeding following injury, tooth extraction or surgery?			
6. Have any infectious diseases (including HIV or hepatitis)?			
7. Take, or have you taken, steroids?			
DID YOU, as a child, or since, have:			
1. Growth hormone treatment before the mid 1980s?			
2. A close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease?			
3. Heart surgery?			
4. Brain surgery?			
DRINKING:			
How many units of alcohol do you drink per week? (A unit of alcohol is half a pint of lager, a single measure of spirits, or a single glass of wine/aperitif)			**_____ units per week**
SMOKING AND CHEWING:			
Do you smoke any tobacco products, now or in the past?			**_____ per day**
Do you chew tobacco, betel-quid, gurkha or supari, now or in the past?			**_____ per day**

Please give any other details which your dentist might need to know about, such as self-prescribed medicines, (e.g. aspirin):

_____

_____

Completed by: (Please tick) Self: ☐ **Parent:** ☐ **Guardian:** ☐

I agree to this information being made available to other healthcare professionals as may be necessary.

Signature:_____ **Date:** _____

Medical History Update Please check that the health information on his 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