Confidential Medical History Form

Passage House Dental Care

modern dentistry for all

Surname	First Name Mr/Mrs/Miss/Ms
Date of Birth	Occupation
Address Postcode	Telephone Nos. H W M
Your Doctor's name and address	

	YES	NO	DETAILS
Are you attending or receiving treatment from a doctor, specialist, clinic or hospital? (Please give details)			
Are you taking any tablets, medicines, creams or ointments ? (If so please list names and dosage,continue overleaf if required)			
Are you being treated, or have you been treated with steroids in the past two years?			
Are you pregnant? (If so how many weeks)			
Do you take the oral contraceptive pill?			
Have you ever had rheumatic fever, endocarditis, heart valve replacement or any other heart surgery?			
Have you ever had heart or blood pressure problems, including angina, raised blood pressure, heart attack or stroke?			
Have you ever had liver or kidney disease?			
Do you suffer with any infectious diseases, including HIV and hepatitis?			
Do you suffer from asthma, bronchitis or any other chest condition?			
Do you suffer from fainting attacks, giddiness, or epilepsy?			
Do you suffer with diabetes?			
Do you suffer with any allergies to medicines or substances e.g. penicillin, latex?			
Do you carry a warning card for any medical condition?			
Do you smoke any tobacco products now (or did you in the past)? If yes, how many cigarettes per day?			
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)?			
Do you drink alcohol? (How many units do you consume per week? 1 unit=1/2 pint beer, 1 glass wine,1 25 ml measure spirits)			
Are there any other aspects about your health that your dentist should know about?			

Completed by: Self / Parent / Guardian

Signature: .... Date: ....