Winchester House Dental Practice

CONFIDENTIAL MEDICAL HISTORY and CONSENT

Please complete this form to provide important information to help us treat you safely. Please make notes on the reverse of the form, if necessary, particularly any other details we may need to know about you. If you are not sure of any of the questions please inform your Dental Surgeon. This information is confidential and will be retained at the Practice.

Name: _____
Surname First Names Dr / Mr / Mrs / Miss / Ms

Date of Birth: day_____month _____year ____ Occupation: _____

Home Address: _____

_____ Post Code _____

The Practice may use contact details to send text message reminders of your appointments. If you **DO NOT** want any of the details to be used in this way, please place an **X** in the Text Msg box.

Home Phone: _____ Text Msg ☐ Work Phone: _____ Text Msg ☐
Mobile: _____ Text Msg ☐ Alternative Contact: _____ Text Msg ☐

(Please specify Fax, Email, Next of Kin)

Person to contact in an emergency: _____ Phone No: _____

Medical Doctors Name: _____ Phone No: _____

Address: _____

1. Do you or have you ever suffered from any of the following? **PLEASE TICK** as appropriate.

- ☐ A bad reaction to general or local anaesthetic
- ☐ Any heart problems, heart surgery, angina, stroke or Blood Pressure
- ☐ Bruising or persistent bleeding following injury, tooth extraction or surgery
- ☐ Bronchitis asthma or other chest conditions
- ☐ Arthritis
- ☐ Blood refused by the blood transfusion service
- ☐ Bone or joint disease
- ☐ Severe Headaches
- ☐ Epilepsy, giddiness, blackouts, fainting attacks
- ☐ Liver disease (e.g. jaundice, hepatitis - type A, B, C) or kidney disease
- ☐ Diabetes (or does anyone in your family)
- ☐ Drug Dependence
- ☐ Gastric Problems
- ☐ Cold Sores
- ☐ Depressive Illness

2. Have you ever suffered allergies to medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods? Yes / No
Details: _____

3. Are you taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)? Yes / No
PLEASE GIVE DETAILS: _____

_____

_____

4. Are you currently receiving treatment from a doctor, hospital or clinic? Yes / No
Details: _____

5. Have you had treatment that required you to be in hospital? Yes / No
Details: _____

6. Have you had any prosthetic surgery? (eg Heart Valve or Hip Replacement) Yes / No
Details: _____

7. Are you pregnant or possibly pregnant? Yes / No If so, Expected Due Date: _____ Yes / No

8. Have you ever suffered from any other serious illness or infectious disease? Yes / No
PLEASE GIVE DETAILS: _____

9. Average weekly consumption of alcohol _____units.

10. Do you smoke in any format - E-cigs, chew tobacco, pan, use gutkha or supari (or did in the past)? Yes / No
If yes, quantity - _____

PATIENTS/PARENTS/GUARDIAN SIGN HERE: _____ Date: _____

FOR NEW PATIENTS ONLY

1. Name of Last Dentist: _____ 2. Date of last visit _____
3. Do you have Dental pain or a Dental problem at present? Yes / No
   Details: _____
4. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Yes / No
5. Do you become anxious or uncomfortable when you are having dental treatment? Yes / No