

CLAYHALL DENTAL CARE

Confidential Medical History

Name:
Address:
Home Phone:

DOB:
Email:
Mobile:

Name of Doctor:	Emergency Contact:
Practice Name:	Emergency Contact Phone:
Practice Phone:	Relationship:

Lifestyle	<input type="checkbox"/>	Smoke tobacco products? (Per day)	<input type="checkbox"/>	High sugar/ frequency	Details:
	<input type="checkbox"/>	Chew tobacco, pan, gutka, supari (Per day)	<input type="checkbox"/>	Lots fizzy/acidic drinks	
	<input type="checkbox"/>	Consume alcohol? (units per week)	<input type="checkbox"/>	Recreational drugs	
	<input type="checkbox"/>	Anything else the dentist should know	<input type="checkbox"/>	Pregnant (possibly)	

Heart	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Heart Murmur	Details:
	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	Angina	
	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	Thrombosis	
	<input type="checkbox"/>	Pacemaker Fitted	<input type="checkbox"/>	Other Heart conditions	

Blood	<input type="checkbox"/>	Hepatitis A, B, C, D	<input type="checkbox"/>	Anaemia	Details:
	<input type="checkbox"/>	H.I.V. / AIDS	<input type="checkbox"/>	Sickle Cell	
	<input type="checkbox"/>	Abnormal Blood Test Result	<input type="checkbox"/>	Haemophilia	
	<input type="checkbox"/>	Blood refused by transfusion service	<input type="checkbox"/>	Other Blood conditions	

Allergies	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	Latex	Details:
	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Medicines	
	<input type="checkbox"/>	Anti-Tetanus Serum	<input type="checkbox"/>	Plants	
	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Foods	
	<input type="checkbox"/>	Reaction to General Anaesthetic	<input type="checkbox"/>	Aspirin	
	<input type="checkbox"/>	Reaction to Local Anaesthetic	<input type="checkbox"/>	Other Allergy	

Warnings	<input type="checkbox"/>	Hearing/Sight Impairment	<input type="checkbox"/>	Problem being reclined	Details:
	<input type="checkbox"/>	Antibiotic Cover required	<input type="checkbox"/>	Steroids in last 2 years	
	<input type="checkbox"/>	Any treatment that required a hospital	<input type="checkbox"/>	Warning Card	
	<input type="checkbox"/>	Bruising or persistent bleeding after injury, surgery or tooth extraction			
	<input type="checkbox"/>	Currently under treatment of a doctor, hospital or clinic			

Chest	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Emphysema	Details:
	<input type="checkbox"/>	Cystic Fibrosis	<input type="checkbox"/>	Pneumonia	
	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	Chest Surgery	
	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Other Chest Conditions	

Medication	List and state doses for any prescribed medicines, tablets, ointments, injections or inhalers (inc. contraceptives and HRT) you are taking:
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Other	<input type="checkbox"/>	Liver Disease (e.g. jaundice)	<input type="checkbox"/>	Kidney Disease	Details:
	<input type="checkbox"/>	Diabetes / Family with Diabetes	<input type="checkbox"/>	Epilepsy	
	<input type="checkbox"/>	Acid Reflux or Eating disorder	<input type="checkbox"/>	Hiatus Hernia	
	<input type="checkbox"/>	Bone or Joint disease	<input type="checkbox"/>	Artificial Joint	
	<input type="checkbox"/>	Fainting Attacks or Blackouts	<input type="checkbox"/>	Giddiness	
	<input type="checkbox"/>	Any past Serious or Infectious disease	<input type="checkbox"/>	Cancer / Radiotherapy	
	<input type="checkbox"/>	Depressive Illness	<input type="checkbox"/>	Stroke	
	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	Tuberculosis	
	<input type="checkbox"/>	Severe Headaches	<input type="checkbox"/>	Cold Sores	

Signed by: Date: