# medical history

ELMSLEIGH HOUSE DENTAL CLINIC
experience excellence

In common with all dentists we ask you for information about your general health to help us treat you safely. Please give us your contact details below, complete the health questions and sign the form. On subsequent visits please inform us if there has been any change in your general health. All information will be kept strictly confidential and used only by us.

Surname ..... First name(s) ..... Title.....

Male ◯ Female ◯ Date of birth...../...../..... Occupation .....

Address ..... Postcode.....

Home tel ..... Work tel ..... Mobile ..... Email .....

Doctor's name ..... Doctor's tel.....

Doctor's address ..... Postcode.....

## ARE YOU CURRENTLY:

Yes ✓ No

**Receiving treatment from a doctor, hospital, clinic or specialist?** ◯ ◯

Details .....

**Taking any prescribed medicines** (tablets, ointments, injections, inhalers, HRT, contraceptives)**?** ◯ ◯

Details .....

**Carrying a medical warning card?** ◯ ◯

Details .....

**Pregnant?** ◯ ◯

Expected delivery date.....

## DO YOU SUFFER FROM:

Yes ✓ No

**Allergies to any medicines** (eg penicillin), **substances** (latex or rubber), **or foods?** ◯ ◯

Details .....

**Hay fever or eczema?** ◯ ◯

Details .....

**Bronchitis, asthma or other chest condition?** ◯ ◯

Details .....

**Fainting attacks, giddiness, blackouts or epilepsy?** ◯ ◯

Details .....

please continue overleaf

## DO YOU SUFFER FROM:

Yes ✓ No

Heart problems, angina, blood pressure problems or stroke?
Details.....

Diabetes (or does anyone in your family)?
Details.....

Arthritis?
Details.....

Bruising or persistent bleeding after injury, tooth extraction or surgery?
Details.....

Any infectious diseases (including HIV)?
Details.....

Drinking:
How many units of alcohol do you drink per week?
(A unit is a half pint of lager, a single measure of spirits or a single glass of wine/aperitif .....

Smoking:
Do you smoke or use tobacco products?
(List here cigarettes, cigars etc.)

Yes ..... per day  Yes, in the past ..... per day  No

## HAVE YOU, AS A CHILD OR SINCE, HAD:

Yes ✓ No

Rheumatic fever?
Details.....

Liver disease (ie. jaundice, hepatitis) or kidney disease?
Details.....

Any serious illness?
Details.....

Blood refused by the Blood Transfusion Service?
Details.....

A bad reaction to a general or local anaesthetic?
Details.....

Had a joint replacement or implant?
Details.....

Treatment that required you to be in hospital?
Details.....

A pacemaker or any form of heart surgery?
Details.....

Are there any other aspects we should know concerning your health?.....

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Completed by: self parent guardian Signature..... Date .....