Confidential Medical History Lincoln House Dental Practice

Forename:
Surname:
D.O.B.:

Medication

Are you taking any medication? Please list below

Have you ever had any of the following?
(please tick any that apply and give details if needed)

Heart

- High / Low Blood Pressure
- Rheumatic Fever
- Heart Surgery
- Pacemaker Fitted
- Heart Murmur
- Angina
- Other Heart Condition DETAILS...

Chest

- Bronchitis
- Emphysema
- Pneumonia
- Chest Surgery
- Cystic Fibrosis
- Pleurisy
- Asthmatic
- Other Chest Condition DETAILS …..

Blood

- Bruising or persistent bleeding
- Anaemia
- Abnormal Blood Test Result
- Sickle Cell
- Haemophilia
- Thrombosis
- Hepatitis A,B,C,D
- H.I.V. / AIDS
- Blood refused by transfusion svce.
- Other Blood Condition DETAILS..

Allergies

- Penicillin
- Hay Fever
- Anti-Tetanus Serum
- Eczema
- Aspirin
- Latex
- Local Anaesthetic
- Medicines
- Plants
- Foods
- General Anaesthetic
- Other Allergy DETAILS ….

Other

- Hearing or Sight Impairment
- Cold Sores
- Diabetes / Family with Diabetes
  Liver Disease
- Kidney Disease
- Epilepsy Tuberculosis
- Cancer / Radiotherapy
- Hiatus Hernia
- Acid Reflux or Eating Disorder
- Bone or Joint Disease
- Artificial joint
- Fainting Attacks or Blackouts
- Giddiness
- Stroke
- Past serious or infectious disease
- Depressive Illness
- Nervous Problems
- Severe Headaches

Warnings

- Antibiotic cover required
- Prefer not to lie flat
- Pregnant or possibly pregnant DUE DATE?
- Carry a Warning Card DETAILS ...
- Steroids in last 2 years
- Currently under treatment DETAILS ...

Lifestyle

Do you have a high sugar diet?
Do you drink lots of fizzy/acidic drinks?
Do you drink alcohol? (how many units per week)
Do you smoke? (how much per day)
Do you chew tobacco? (how much per day)
Do you use recreational drugs?

Is there anything else you think we should know?

Signature:
Date:
(Patient, Parent,Guardian or Carer)
Address:

Phone number: (home) (mobile)

Email address:

Which is the best way to contact you?

Doctor's Name:

Practice Phone:

Practice Name: