Somerhill

Medical History

In common with all dentists,we ask you for information about your general health to help us treat you safely. Please complete and sign this form and, on subsequent visits, please tell us if there has been any change in your general health. All information will be kept strictly confidential and used only by Somerhill Dental.

Surname | First name | Title

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

Address

Postcode | Email

Tel (h) | (w) | (m)

Doctor's name | Doctor's tel

Doctor's address | Postcode

Do you have any children? ◯ Yes ◯ No | If yes, please give age(s)

Are you currently:

Attending or receiving treatment from a doctor, hospital, clinic or specialist? ◯ Yes ◯ No
Details

Carrying a medical warning card? ◯ Yes ◯ No
Details

Taking ANY prescribed medicines (and/or taken steroids or alendronic acid in the past 2 years)? ◯ Yes ◯ No
Details

Pregnant? ◯ Yes ◯ No
Due date

Do you suffer from:

Allergies to any medicines (eg penicillin, aspirin), substances (eg latex/rubber) or foods? ◯ Yes ◯ No
Details

Diabetes (or does anyone in your family)? ◯ Yes ◯ No
Details

Bronchitis, asthma or other chest condition? ◯ Yes ◯ No
Details

Arthritis? ◯ Yes ◯ No
Details

Hay fever or eczema? ◯ Yes ◯ No
Details

Bruising or persistent bleeding after injury, tooth extraction or surgery? ◯ Yes ◯ No
Details

Fainting, giddiness, blackouts or epilepsy? ◯ Yes ◯ No
Details

Any infectious diseases (including HIV, Hep B, Hep C)? ◯ Yes ◯ No
Details

Heart problems, angina, blood pressure problems or stroke? ◯ Yes ◯ No
Details

Excessive bleeding, bruising or haemophilia? ◯ Yes ◯ No
Details

Please continue overleaf

Have you, as a child or since, had:

Rheumatic fever, chorea or St Vitus' Dance? ◯ Yes ◯ No
Details

A bad reaction to a general or local anaesthetic? ◯ Yes ◯ No
Details

Liver disease (ie jaundice, hepatitis) or kidney disease? ◯ Yes ◯ No
Details

Had a joint replacement or implant? ◯ Yes ◯ No
Details

Any serious illness or operation in the last 3 years? ◯ Yes ◯ No
Details

Treatment that required you to be in hospital? ◯ Yes ◯ No
Details

Blood refused by the Blood Transfusion Clinic? ◯ Yes ◯ No
Details

A pacemaker or any form of heart surgery? ◯ Yes ◯ No
Details

CJD? ◯ Yes ◯ No
Details

Growth hormone treatment before the mid 1980s? ◯ Yes ◯ No
Details

Drinking:

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

Smoking:

Do you smoke or use any tobacco products? ◯ Yes ◯ No

Type (cigarettes, cigars etc)?

Number per day? In the past, number per day?

Other:

Are there any other aspects concerning your health that we should be aware of? ◯ Yes ◯ No
Details

Completed by: ◯ Self ◯ Parent ◯ Guardian

Patient signature Dentist signature

Date / /

I confirm there are no changes to my medical health since this form was last completed.

Patient signature Dentist signature

Date / /

Patient signature Dentist signature

Date / /

Patient signature Dentist signature

Date / /