

Confidential Medical History Form

We ask you for information about your general health to help us treat you safely. Please write your contact details below, answer the health questions inside then sign the form on the back page. We will use this form at later visits to discuss any change in your general health. All information will be kept strictly confidential by the people caring for you.

Surname _____

First Name/s _____ Title _____

Sex Male Female

Date of Birth day ____ month ____ year ____

Address _____

Postcode _____

Telephone home _____

mobile _____

In the event of an emergency, please contact: Name _____
Number _____

Email _____

Occupation _____

Doctor's name and address _____

Doctor's telephone _____



Are you currently

yes

no

Give details

Receiving treatment from a doctor, hospital or clinic?

Taking any prescribed medicines (eg tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?

Carrying a medical warning card?

Pregnant or possibly pregnant?

Have you ever suffered from

yes

no

Give details

Allergies to medicines (eg penicillin), substances (eg latex/rubber) or foods?

Bronchitis, asthma or other chest condition?

Fainting attacks, giddiness, blackouts, epilepsy?

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

Diabetes (or does anyone in your family)?

Bone or joint disease?

Bruising or persistent bleeding following injury, tooth extraction or surgery?

Liver disease (eg jaundice, hepatitis) or kidney disease?

Any other serious illness or infectious disease?

Blood refused by the Blood Transfusion Service?

Completed by (please tick) self parent guardian

Patient's signature _____ Date _____

Dentist's signature _____ Date _____

Medical history update

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

| Date | No change | List any changes below | Patient's initials |
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