denpure

Dental Care & Implant Centre

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 and 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

TITLE

FIRST NAME

DATE OF BIRTH

ADDRESS

SEX Male ☐ Female ☐

POSTCODE

HOME TEL

MOBILE

EMAIL

OCCUPATION

In the event of an emergency please contact:

NAME

TEL

Your Doctor's details:

DOCTOR'S NAME

DOCTOR'S ADDRESS

DOCTOR'S TEL

Are you currently	YES	NO	Please give details
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines (eg aspirin, tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy?			
Have you taken steroids in the last 2 years?			
Carrying a medical warning card?			
Pregnant or possibly pregnant?			

Have you ever suffered from	YES	NO	Please give details
Allergies to any medicines (eg penicillin)?			
Allergies to any substances or foods (eg latex, rubber)			
Hayfever or any other allergies?			
Bronchitis, asthma or other chest conditions?			
Fainting attacks, angina, blood pressure problems or stroke, epilepsy?			
Cold Sores?			
Do you have a pacemaker or artificial joint?			

	YES	NO	Please give details
Diabetes (or does anyone in your family)?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Liver disease (eg jaundice, hepatitis) or kidney disease?			
Any infectious diseases (including HIV and hepatitis)?			
Blood refused by the Blood Transfusion Service?			

Have you, as a child or since, had	YES	NO	Please give details
A bad reaction to general or local anaesthetic?			
Treatment that required you to be in hospital?			
Heart Surgery/heart murmur?			
Rheumatic fever?			

Alcohol

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

Tobacco use	YES	NO	IN PAST	
Do you smoke any tobacco products now (or in the past)?				TIMES PER DAY
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)?				TIMES PER DAY

Please give any other details which your dentist might need to know about, such as self-prescribed medicines (eg Aspirin)

COMPLETED BY SELF/ PARENT/GUARDIAN	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 please would you amend as necessary.

Date	Any changes?	List any changes below	Patient/Dentist Initials

☐ Please note your dentist may use x-rays or clinical photography for research and lectures. Please tick if you do not give permission for this.

☐ We may also display before and after clinical photos on our website which will not identify you. Please tick if you do not wish to give permission for this.

denpure

Dental Care & Implant Centre

Denpure Dental Care 77 Swakeleys Road, Ickenham, Uxbridge, UB10 8DQ

Tel 01895 678 889 Email info@denpure.co.uk Web www.denpure.co.uk