Medical history update

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

Date	No changes	List changes below	Initials

DO NOT COMPLETE

Medical and Social 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. We will use this form at later visits to discuss any change in your general health. This information will be kept strictly confidential.

Russell Street DENTAL CLINIC

Title: Last Name:

First Name:

Date of Birth: Sex: Male Female

Address

Postcode

Telephone: (Home Number)

Mobile Number:

Email:

Occupation:

First Language: **Nationality:**

School: (18 years + under only)

In the event of an emergency, please contact

Name:

Telephone Number: Relationship to you:

Doctor's Medical Practice. (Enter the name)

HABITS

Smoke (per day) _____

Chew Tobacco (per day) _____

Alcohol (unit per week) _____

High sugar/frequency ☐

Lots of fizzy/acidic drinks ☐

Recreational drugs ☐

None of these ☐

Details / Other

HEART

Rheumatic fever ☐

High blood pressure ☐

Heart surgery ☐

Pacemaker fitted ☐

Heart murmur ☐

Angina ☐

Thrombosis ☐

None of these ☐

Details / Other

ALLERGIES

Penicillin ☐

Hay Fever ☐

Anti Tetanus Serum ☐

Eczema ☐

General Anaesthetic ☐

Local Anaesthetic ☐

Latex Allergy ☐

Medicines ☐

Plants ☐

Foods ☐

Asprin ☐

None of these ☐

Details / Other

BLOOD

Hepatitis B ☐

H.I.V. ☐

Abnormal Blood Test ☐

Blood refused by transfusion service. ☐

Anaemia ☐

Sickle Cell ☐

Haemophilia ☐

None of these ☐

Details / Other

WARNINGS

Pregnant or possibly pregnant ☐

Antibiotic cover required ☐

Bruising or persistant bleeding ☐

Currently under treatment ☐

Anything dentist should know ☐

Do not recline ☐

Steroids within 2 years ☐

Warning card ☐

Treatment requiring hospitalisation ☐

None of these ☐

Details / Other

CHEST

Bronchitis ☐

Cystic Fibrosis ☐

Pleurisy ☐

Asthmatic ☐

Emphysema ☐

Pneumonia ☐

Chest Surgery ☐

None of these ☐

Details / Other

OTHER

Liver Disease ☐

Diabetes ☐

Acid Reflux or Eating Disorder ☐

Bone or Joint Disease ☐

Fainting Attacks or Blackouts ☐

Past serious or infectious disease ☐

Kidney Disease ☐

Epilepsy ☐

Hiatus Hernia ☐

Artificial Joint ☐

Giddiness ☐

Cancer ☐

None of these ☐

MEDICATION / DISABILITIES

Please list any prescribed or self-prescribed medicines you are taking.
Also detail any disabilities you may have

NHS TREATMENT: Are you entitled to free (exempt) dental treatment

Yes ☐ No ☐ If yes please state reason why

Completed by: please tick Self ☐ Parent ☐ Guardian ☐

Signature SIGN IN THE SURGERY Date

Clinic Signature Date