Confidential Medical History Form

elite endo
ADVANCED CLINIC FOR SAVING TEETH

Medications, medical conditions, and allergies can affect dental treatment. So, to obtain the best and safest care, our dentist needs to know of any problems which may affect your treatment.

Please ensure that you answer **ALL** the questions on this form and all contact details are filled out correctly.
Thank you.

Your Full Name:					
Title:		Date of Birth:		Sex:	Male / Female
Home Address:					
Post Code:					
Home Tel:		Work Tel:			
Mobile Tel:		Occupation:			
Email Address:					
Medical Doctor's Name:					
Medical Doctor's Address:					

Are you?	**Yes**	**No**	**Please provide details if you tick 'Yes'**
Attending or receiving treatment from a doctor, hospital or clinic or specialist?			
Taking or have taken steroids in the last 2 years?			
Carrying a medical warning card?			
Taking any blood-thinning medications such as *Warfarin, Aspirin, Clopidogrel, Dabigratran?* **Please specify and give your most recent INR** if applicable.			
Taking Bisphosphonates or have you in the past 10 years *(e.g. Alendronic Acid/Risedronate/Etidronate)*			
Wearing a pacemaker?			

Do you suffer from?	**Yes**	**No**	**Please provide details if you tick 'Yes'**
Allergies to any medicines *(e.g. Penicillin)*, Substances *(e.g. latex/rubber)* or foods *(e.g. nuts/shellfish)*?			
Hay fever or eczema?			
Bronchitis, emphysema, COPD other chest / lung conditions?			
Asthma? How severe? Do you use inhalers?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart conditions, angina, stroke? Heart surgery?			
Diabetes? Type 1, Type 2? Medications taken?			
Blood pressure? Taking any blood pressure medications?			
Arthritis, Osteoporosis or other bone/joint disease?			
Thyroid problems? Over or under active?			
Liver or Kidney Disease? Or had jaundice?			
Any infectious disease (*e.g. HIV, Hepatitis B, C, or D, HPV?*)			

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Have you ever had?	Yes	No	Please provide details if you tick 'Yes'
Radiotherapy or Chemotherapy?			
A bad reaction to local or general Anaesthetic?			
An operation in the last 24 months?			
Allergic reaction?			
CJD?			

Women Only	Yes	No	Please provide details if you tick 'Yes'
Is there any possibility you may be pregnant? If yes when is your due date?			
Have you had a baby in the last 12 months? If yes what date was your baby born?			
Are you breastfeeding?			

Alcohol and Smoking	Yes	No	Please provide details if you tick 'Yes'
How many units of alcohol do you drink per a week? (a unit is a half pint of lager, a single measure of spirit or a single glass of wine)			
Do you smoke any tobacco products now or in the past? If yes how many a day and total years smoked?			

List of prescribed medications

Patients Signature:..... Date:.....

BDA Good Practice
CELEBRATING 10 YEARS Member