CONFIDENTIAL MEDICAL HISTORY

NAME:			**DOB:**
ADDRESS:			
TEL NUMBERS:	**HOME:**		**MOBILE:**
EMAIL ADDRESS:			
DOCTOR'S NAME:		**DOCTOR'S ADDRESS:**	
DOCTOR'S TEL NO:			
NEXT OF KIN NAME AND TEL:			

	ARE YOU:	**YES**	**NO**	**DETAILS:**
1	RECEIVING TREATMENT FROM A DOCTOR, HOSPITAL OR CLINIC?			
2	TAKING ANY PRESCRIBED MEDICINES?			
3	TAKING OR TAKEN STEROIDS IN THE LAST TWO YEARS?			
4	ALLERGIC TO ANY MEDICINES, FOODS, OR MATERIALS?			
5	CARRYING A MEDICAL WARNING CARD?			
6	PREGNANT?			
	DO YOU HAVE:	**YES**	**NO**	
7	ANY ALLERGIES?			
8	BRONCHITIS, ASTHMA OR OTHER CHEST CONDITIONS?			
9	EPILEPSY?			
10	HEART PROBLEMS/ANGINA?			
11	HEART SURGERY?			
12	HIGH OR LOW BLOOD PRESSURE?			
13	DIABETES?			
14	BONE OR JOINT DISEASE?			
15	BLOOD DISORDER?			
16	DO YOU TAKE WARFARIN? IF SO WHAT IS YOUR MOST RECENT INR READING?			
17	LIVER DISEASE (e.g. jaundice/hepatitis)			
18	ANY OTHER INFECTIOUS DISEASES/ILLNESSES (E.G HIV)			
19	BAD REACTION TO LOCAL ANAESTHETIC?			
20	DO YOU SUFFER WITH ACID REFLUX OR STOMACH PROBLEMS?			
	HOMECARE:	**YES**	**NO**	
21	DO YOU BRUSH YOUR TEETH? IF SO HOW OFTEN?			
22	DO YOU USE MOUTH WASH?			
23	DO YOU USE A TOOTHPASTE CONTAINING FLUORIDE?			
24	DO YOU USE INTERDENTAL BRUSHES/FLOSS? IF SO HOW OFTEN?			
	GENERAL:	**YES**	**NO**	
25	DO YOU DRINK FIZZY DRINKS? IF SO HOW OFTEN?			
26	DO YOU EAT FOODS WITH A HIGH SUGAR CONTENT DAILY? HOW MUCH?			
27	DO YOU HAVE SUGAR IN HOT DRINKS? IF SO HOW MANY?			
28	DO YOU DRINK ALCOHOL? HOW MUCH PER WEEK?			
29	DO YOU CLENCH OR GRIND YOUR TEETH?			
30	DO YOU SMOKE? IF SO HOW MANY PER DAY?			

COMPLETED BY: SELF/PARENT/GUARDIAN

DATE:.....SIGNATURE:.....

HAVE THERE BEEN ANY CHANGES IN YOUR HEALTH SINCE YOUR LAST COURSE OF TREATMENT?

YES/NO DATE:.....SIGNATURE:.....DENTIST SIGNATURE:.....
YES/NO DATE:.....SIGNATURE:.....DENTIST SIGNATURE:.....
YES/NO DATE:.....SIGNATURE:.....DENTIST SIGNATURE:.....
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