COMPLETED BY (PLEASE TICK): ☐ Self ☐ Parent ☐ Guardian

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	Patients Initials

SADP. 0119

CONFIDENTIAL MEDICAL HISTORY FORM

Here at Steyning Avenue Dental Practice, we ask our patients for information about their general health to enable us to treat you safely whilst in our care. Please complete your contact details and general health questionnaire below. This will then be updated every six months going forward to help keep your records up to date with any changes. This includes general health, address, telephone numbers and consent for possible radiographs. All information that you provide to us will be kept strictly confidential between the dental staff and yourself here at Steyning Avenue Dental Practice.

It is recommended that X-rays be used occasionally to assist in the diagnosis of decay, infection, bone loss due to periodontal disease, and to aid in the delivery of procedures such as extractions and root treatments. No other reasonable option for dental radiographs exists currently. Any diagnostic procedure employing the use of X-rays carries a risk. Dental x-rays expose the patient to a minimal dose of radiation, which is considered to be a justified balance against the risk of not having the diagnostic information, such as x-rays. If you are pregnant or may be pregnant, please advise your dentist before any radiographs are carried out.

Do you have DNR (Do Not Resuscitate)? ☐ **YES** ☐ **NO**

Surname _____

First Name/s _____ title _____

Sex ☐ male ☐ female

Date of birth ☐ day ☐ month ☐ year

Address _____

_____

_____ postcode _____

Telephone home _____ Mobile _____

Occupation _____

Doctor's name and address _____

_____

Doctor's telephone _____

Your E-mail _____

ARE YOU CURRENTLY

	Yes	No	----->Give details<---
Pregnant?	☐	☐	
Receiving treatment from a doctor, hospital or clinic?	☐	☐	
Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?	☐	☐	
Carrying a medical warning card?	☐	☐	

DO YOU SUFFER FROM

	Yes	No	----->Give details<----
Allergies to any medicines(e.g. penicillin), substances (e.g. latex/rubber) or foods?	☐	☐	
Hay fever or eczema?	☐	☐	
Bronchitis, asthma or any other chest condition?	☐	☐	
Fainting attacks, giddiness blackouts, epilepsy?	☐	☐	
Heart problems, angina, blood pressure problems, or stroke?	☐	☐	
Diabetes (or does anyone in your family)?	☐	☐	
Arthritis?	☐	☐	
Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐	☐	
Any infectious diseases (including HIV and hepatitis)?	☐	☐	

DID YOU, AS A CHILD OR SINCE, HAVE

	Yes	No	----->Give details<----
Rheumatic fever or chorea?	☐	☐	
Liver disease (e.g. jaundice, hepatitis)	☐	☐	
or kidney disease?Any other serious illness?	☐	☐	

DID YOU, AS A CHILD OR SINCE, HAVE

	Yes	No	----->Give details<----
Blood refused by the Blood Transfusion Service?	☐	☐	
A bad reaction to general or local anaesthetic?	☐	☐	
A joint replacement or other implant?	☐	☐	
Treatment that required you to be in the hospital?	☐	☐	
Heart surgery?	☐	☐	
Brain surgery?	☐	☐	
Growth hormone treatment before the 1980s?	☐	☐	
A close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease?	☐	☐	

DRINKING

How many units of alcohol do you drink per week?
A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitif? ☐ Units per week

SMOKING AND CHEWING

	Yes	No	In past	
Do you smoke any tobacco products? now (or did you in the past)?	☐	☐	☐	☐ Times per day
Do you Vape?	☐	☐	☐	☐ Times per day
Do you chew tobacco, pan, or use gutkha? or supari now (or did you in the past)?	☐	☐	☐	☐ Times per day

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PLEASE GIVE ANY OTHER DETAILS WHICH YOUR DENTIST MIGHT NEED TO KNOW ABOUT, SUCH AS SELF-PRESCRIBED MEDICINES (E.G. ASPIRIN).