CityDental Leicester

## Confidential Medical History

To provide the best and safest treatment your dentist needs to know of any problems which may affect your treatment

| | | |
|---|---|---|
| Title: | DOB: | Sex: Male / Female |
| Surname: | Forename | |
| Address: | | |
| | Postcode: | |
| Tel(home): | Tel(work): | |
| Email: | NHS Number: | |
| Your Doctors Name and Address: | | |
| | | |
| When did you last receive dental treatment: | | |

| | YES | NO | If yes, please give some detail |
|---|---|---|---|
| Are you attending or receiving treatment from a doctor, hospital, and specialist? | | | |
| Are you taking any medicines, tablets, drugs or injections, or using any cream ointments or inhalers? | | | |
| Are you taking or have you taken steroids in the last 2years? | | | |
| Are you allergic to penicillin? | | | |
| Are you allergic to any medicine, food or materials? | | | |
| Are you pregnant or nursing mother? | | | |
| Are you HIV positive? | | | |
| Have you had rheumatic fever or chorea? | | | |
| Have you had jaundice, liver, kidney disease or hepatitis? | | | |
| Have you ever been told you have a heart murmur, heart problems, angina or high blood pressure? | | | |
| Have you ever had your blood refused by the blood Transfusion Service? | | | |
| Have you ever had a bad reaction to a local or general aesthetic? | | | |
| Have you had a joint replacement or other implant? | | | |
| Have you been hospitalised for any reason? | | | |
| Do you have arthritis | | | |
| Do you have a pacemaker or have you had heart surgery? | | | |
| Do you suffer from hay fever, eczema or any other allergy? | | | |
| Do you suffer bronchitis, asthma or other chest conditions? | | | |
| Do you have fainting attacks, giddiness, blackouts or epilepsy? | | | |
| Do you have diabetes or anyone in your family? | | | |
| Do you bruise easily or suffer persistent bleeding following a tooth extraction or injury or anyone in your family? | | | |
| Do you carry a warning card? | | | |
| Do you think there are any other aspects concerning your health that your dentist should know? | | | |
| On average how much of the following do you consume per day? | Cigarettes ____ | | Alcohol ____ |

Sign …….. Date ……