Confidential Medical History Form

To enable us to treat you safely we are required to ask you for some information about your general health. Please fill in your contact detail, answer the health questions and sign the form. At later visits we will check the information given to see if there have been any changes in your general health.

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

MAXILLO
excellence in dentistry

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Title: | First Name: | Surname: | D.O.B.:

Address:

Telephone: | Home: | Work: | Email: | Occupation:

Please sign here: if you agree to us telephoning you and leaving a message at this number:

Your Doctor's Name: | Your Doctor's Address:

ARE YOU:

1. Pregnant? YES NO DETAILS:
2. Attending or receiving treatment from a doctor, hospital, clinic or specialist? YES NO DETAILS:
3. Taking any medicines from your doctor? YES NO DETAILS:
4. Taking or have you taken steroids in the last two years? YES NO DETAILS:
5. Allergic to any medicine (e.g. antibiotics), materials (e.g. latex/rubber) or food? YES NO DETAILS:

HAVE YOU:

1. Had rheumatic fever or chorea (St Vitus Dance)? YES NO DETAILS:
2. Had jaundice, liver, kidney disease or hepatitis? YES NO DETAILS:
3. Had any blood tests? YES NO DETAILS:
4.0 Ever had your blood refused by The Blood Transfusion Service? YES NO DETAILS:
5. Ever been told you have a heart murmur or heart problem, angina, blood pressure or heart attack? YES NO DETAILS:
6. Ever had a bad reaction to a general or local anesthetic? YES NO DETAILS:
7. Had a joint replacement or other implant? YES NO DETAILS:
8. Had growth hormone treatment before the mid 1980's? YES NO DETAILS:
9. Been Hospitalized? If yes' for what and when? YES NO DETAILS:

DO YOU:

1. Have arthritis? YES NO DETAILS:
2. Have a pacemaker? YES NO DETAILS:
3. Suffer from hay fever, eczema or any other allergy? YES NO DETAILS:
4. Suffer from bronchitis, asthma or any other chest condition? YES NO DETAILS:
5. Have fainting attacks, giddiness, blackouts or epilepsy? YES NO DETAILS:
6. Have diabetes? YES NO DETAILS:
7. Bruise easily or persistently bleed following injury, tooth extraction or surgery? YES NO DETAILS:
8. Suffer from any infectious diseases (including H.I.V.)? YES NO DETAILS:
9. Have a close relative with Creutzfeld Jakob Disease? YES NO DETAILS:
10. Carry a Warning Card? YES NO DETAILS:
11. Smoke? If yes, approximately how many each day? YES NO DETAILS:
12. Drink alcohol? If yes, approximately how many units each week? YES NO DETAILS:

SIGNED BY: SELF / PARENT / GUARDIAN: _____ DATE: _____