imogendental

CONFIDENTIAL MEDICAL HISTORY FORM

Surname:	First name(s):
Date of birth:	Title: Gender:
Home address:	
Home telephone number:	Mobile:
Email:	Occupation:
Doctor's name & address: Tel:	
Contact in case of an emergency: Relation: Tel:	

What is your ethnic group?
(Please tick)

☐ White British	☐ White Irish	☐ Other White background
☐ White & Black Caribbean	☐ White & Black African	☐Asian or Asian British Pakistani
☐Asian or Asian British Indian	☐ Asian or Asian British Bangladeshi	☐ Other Asian background
☐ Black or Black British African	☐ Black or Black British Caribbean	☐ Other Black background
☐ Other mixed background	☐Chinese	☐ Any other ethnic group
☐ Patient declined		

(Please circle)

Is your current BMI (Body Mass Index) over 30?	Yes / No	Do you drink alcohol? If so, how many units per week?	Yes / No
Receiving treatment from a doctor, hospital, or clinic? If yes, please give details:	Yes / No	Do you smoke? If so, how many per day?	Yes / No __________
Carrying a medical warning card? If yes, please give details:	Yes / No	Have you ever smoked?	Yes / No
Pregnant? If yes, please give due date:	Yes / No	Do you chew tobacco products?	Yes / No _____ times per
Do you experience chest pain upon exertion (angina pectoris)? Have you had to reduce your activities? Do you have chest pain at rest?	Yes / No Yes / No Yes / No	Have you ever had a heart attack? Do you still have complaints? Have you had a heart attack in the last 6 months?	Yes / No Yes / No Yes / No

Question	Answer	Question	Answer
Have you every had high blood pressure?	Yes / No	Have you had heart or vascular surgery in the last 6 months?	Yes / No
Do you have a heart murmur, heart valve dysfunction or an artificial heart valve? If so, which:	Yes / No ____________	Do you tend to bleed excessively after injury, surgery or tooth extraction? If so, which:	Yes / No ____________
Do you suffer from spontaneous bruising?	Yes / No	Do you have epilepsy?	Yes / No
Do you suffer from asthma?	Yes / No	Do you have hay fever or eczema? If so, which:	Yes / No ____________
Do you have other lung problems? If so, please name condition:	Yes / No ____________	Have you ever had rheumatic fever?	Yes / No
Have you had endocarditis?	Yes / No	Do you have problems lying flat?	Yes / No
Do you suffer with thyroid disease?	Yes / No	Do you have diabetes? If so, which type:	Yes / No ____________
Have you ever had a stroke?	Yes / No	Do you suffer from cold sores?	Yes / No
Do you have any neurological disorders?	Yes / No	Do you suffer from arthritis? If so, which type:	Yes / No ____________
Do you suffer from liver disease (i.e. jaundice, hepatitis)? If so, have you had a liver transplant?	Yes / No Yes / No	Do you have a kidney disease? Are you undergoing haemodialysis? Have you had a kidney transplant?	Yes / No Yes / No Yes / No
Have you ever had a reaction to a GA or LA? If so, please explain in the box on the right.	Yes / No		
Have you every had an operation? If so, please state what operation in the box on the right.	Yes / No		
Do you have any allergies to any medicines (e.g. antibiotics), substances (e.g. latex/rubber) or foods?	Yes / No	**Allergies:**	
Have you ever had a malignant disease or leukaemia? Have you ever had chemotherapy or a bone marrow transplant? Have you ever had radiotherapy for a tumour or growth in the head or neck?	Yes / No Yes / No Yes / No	Have you suffered from/are suffering from an infectious disease? (e.g. HIV or hepatitis). If so, please give details	Yes / No

Do you take any of the following medication?

☐ For a heart complaint.	☐ Hormone replacement therapy.	☐ For diabetes?	☐ Aspirin or other painkillers.
☐ For high blood pressure.	☐ Drugs against transplant rejection.	☐ For sleeping disorder, depressive conditions or anxiety states.	☐ Corticosteroids (systemic or topical).
☐ For an allergy.	☐ For skin, bowel, or rheumatic diseases.	☐ Contraceptive pill.	☐ Other medication? If so, please specify.

Is there anything else we should know about your general health?

Please list your medication here:

Name	Dose	How long have you taken this medication?

Please sign here to state that all the information given on this medical history form is correct and up to date:

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