SOUTHWOODS CONFIDENTIAL MEDICAL HISTORY

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

NAME: **SEX: MALE / FEMALE**

ADDRESS:

TEL NO: HOME: **WORK:**

DATE OF BIRTH: **OCCUPATION:**

WHEN DID YOU LAST RECEIVE DENTAL TREATMENT:

YOUR DOCTOR'S NAME AND ADDRESS:

PLEASE TICK THE APPROPRIATE BOX

	YES	NO	IF YES ,PLEASE GIVE DETAILS
Are you attending or receiving treatment form a doctor, hospital or specialist?			
Are you taking any medicines, tablets, drugs, injections or using any creams, ointments, inhalers?			
Are you taking or have you taken steroids in the last 2 years?			
Are you allergic to penicillin?			
Are you allergic to any medicines, foods, materials?			
Are you pregnant or a nursing mother?			
Are you HIV positive?			
Have you had rheumatic fever or chorea?			
Have you had jaundice, liver or kidney disease or hepatitis?			
Have you ever been told you have a heart murmur, heart problem, 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 anaesthetic?			
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 from bronchitis, asthma or other chest condition?			
Do you have fainting attacks, giddiness, blackouts or epilepsy?			
Do you have diabetes or does anyone in you family?			
Do you bruise easily or suffer persistent bleeding following a tooth extraction or injury or does anyone in you family?			
Do you carry a warning card?			
Do you think there are any other aspects concerning your health, that your dentist should know about?			

SIGNED **DATE**

Patient / Parent / Guardian (Delete as applicable)