

Confidential medical history

Billingshurst Dental Practice
114 High Street, Billingshurst
West Sussex, RH14 9QS

Forename:

Surname:

D.O.B:

| | | | |
|---------------|---|---|--|
| Habits | <input type="checkbox"/> Smokes (per day) | <input type="checkbox"/> High sugar/frequency | |
| | <input type="checkbox"/> Chews (per day) | <input type="checkbox"/> Lots fizzy/acidic drinks | |
| | <input type="checkbox"/> Alcohol (units per week) | <input type="checkbox"/> Recreational drugs | |

| | | | |
|--------------|--|--|--|
| Heart | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart murmur | |
| | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Angina | |
| | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Thrombosis | |
| | <input type="checkbox"/> Pacemaker fitted | <input type="checkbox"/> Other heart condition | |

| | | | |
|--------------|---|--|--|
| Blood | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Anaemia | |
| | <input type="checkbox"/> H.I.V | <input type="checkbox"/> Sickle cell | |
| | <input type="checkbox"/> Abnormal blood test result | <input type="checkbox"/> Haemophilia | |
| | <input type="checkbox"/> Blood refused by transfusion service | <input type="checkbox"/> Other blood condition | |

| | | | |
|------------------|--|--|--|
| Allergies | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Latex | |
| | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Medicines | |
| | <input type="checkbox"/> Anti-tetanus serum | <input type="checkbox"/> Plants | |
| | <input type="checkbox"/> Eczema | <input type="checkbox"/> Foods | |
| | <input type="checkbox"/> General anaesthetic | <input type="checkbox"/> Aspirin | |
| | <input type="checkbox"/> Local anaesthetic | <input type="checkbox"/> Other allergy | |

| | | | |
|-----------------|--|---|--|
| Warnings | <input type="checkbox"/> Pregnant or possibly pregnant | <input type="checkbox"/> Do not recline | |
| | <input type="checkbox"/> Antibiotic cover required | <input type="checkbox"/> Steroids in last 2 years | |
| | <input type="checkbox"/> Bruising or persistent bleeding | <input type="checkbox"/> Warning card | |
| | <input type="checkbox"/> Currently under treatment | <input type="checkbox"/> Required hospitalisation | |
| | <input type="checkbox"/> Anything dentist should know | | |

| | | | |
|--------------|--|--|--|
| Chest | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Emphysema | |
| | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Pneumonia | |
| | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Chest surgery | |
| | <input type="checkbox"/> Asthmatic | <input type="checkbox"/> Other chest condition | |

Medication

| | | | |
|--------------|---|---|--|
| Other | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Kidney disease | |
| | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | |
| | <input type="checkbox"/> Acid reflux or eating disorder | <input type="checkbox"/> Hiatus hernia | |
| | <input type="checkbox"/> Bone or joint disease | <input type="checkbox"/> Artificial joint | |
| | <input type="checkbox"/> Fainting attacks or blackouts | <input type="checkbox"/> Giddiness | |
| | <input type="checkbox"/> Past serious or infectious disease | <input type="checkbox"/> Cancer | |

Doctor's name:

Emergency contact:

Practice phone:

Contact number:

Practice name:

Relationship:

Patient signature:

Date: