Confidential Medical History

Lifestyle

How many times a day do you smoke tobacco products?

How many time a day do you chew tobacco, pan, gutkha or supari

How many units of alcohol do you consumer per week?

Note: A unit of alcohol is a single measurement of spirits, a glass of wine/aperitif, or half a pint of beer/lager

Yes	No	Is your diet high in sugar/or high frequency?	Yes	No	Do you drink a lot of fizzy or acidic drinks?
Yes	No	Do you use recreational drugs?	Yes	No	Are you or could you be pregnant?
Yes	No	Is there anything else your dentist should know?			

If you ticked anything above please give details:

Heart

Yes	No	Rheumatic Fever	Yes	No	Heart Murmur
Yes	No	High/Low Blood Pressure	Yes	No	Angina
Yes	No	Heart Surgery	Yes	No	Thrombosis
Yes	No	Pacemaker fitted	Yes	No	Other Heart Condition

If you ticked any heart conditions please give details:

Blood

Yes	No	Hepatitis A, B, C, D	Yes	No	Anaemia
Yes	No	H.I.V. / Aids	Yes	No	Sickle Cell
Yes	No	Abnormal Blood Test	Yes	No	Haemophilia
Yes	No	Blood refused by transfusion service	Yes	No	Other Blood Condition

If you ticked any blood conditions please give details:

Allergies

Yes	No	Penicillin	Yes	No	Latex Allergy
Yes	No	Hay Fever	Yes	No	Medicine
Yes	No	Anti-tetanus Serum	Yes	No	Plants
Yes	No	Eczema	Yes	No	Food
Yes	No	General Anaesthetic	Yes	No	Aspirin
Yes	No	Local Anaesthetic	Yes	No	Other Allergy

If you ticked any allergies above please give details:

Warnings

Yes	No	Do you have a hearing or sight impairment?	Yes	No	Do you have a problem being reclined?
Yes	No	Do you require Antibiotic Cover?	Yes	No	Have you had steroids in the last 2 years?
Yes	No	Do you have bruising or persistent bleeding after injury, surgery, or tooth extraction?	Yes	No	Do you carry a Warning Card?
Yes	No	Are you currently having treatment from a doctor, hospital or clinic?	Yes	No	Have you ever had treatment that required you to be hospitalised?

If you ticked any warnings above please give details:

Chest

Yes	No	Bronchitis	Yes	No	Emphysema
Yes	No	Cystic Fibrosis	Yes	No	Pneumonia
Yes	No	Pleurisy	Yes	No	Chest Surgery
Yes	No	Asthma	Yes	No	Other Chest Condition

If you ticked any chest conditions please give details:

Medication

List and state doses for any prescribed medicines, tablets, ointments, injections or inhalers (inc. contraceptives and HRT) that you are taking:

Other

Yes	No	Liver Disease	Yes	No	Kidney Disease
Yes	No	Diabetes	Yes	No	Epilepsy
Yes	No	Acid Reflux or Eating Disorder	Yes	No	Hiatus Hernia
Yes	No	Bone or Joint Disease	Yes	No	Artificial Joint
Yes	No	Fainting attacks or Blackouts	Yes	No	Giddiness
Yes	No	Any Past Serious Illness or Infectious Disease	Yes	No	Cancer / Radiotherapy
Yes	No	Depressive Illness	Yes	No	Stroke
Yes	No	Nervous Problems	Yes	No	Tuberculosis
Yes	No	Severe Headaches	Yes	No	Cold Sores

Please give details for anything ticked above:

Please enter your doctor's contact information

Name of Doctor

Doctor's Phone

Doctor's Practice

Who should we contact in an emergency?

Emergency Contact Name

Emergency Contact Phone Number

Emergency Contact Relationship

Signature (Patient, Parent, Guardian or Carer)

Date: ___/___/___

CONFIDENTIAL DENTAL MEDICAL HISTORY FORM

Patient Name:

Date of Birth:

Contact Number:

Smoking Frequency:

Vaping / E-cigarette Use:

Alcohol Units per Week:

Recreational Drug Use (Yes/No + Details):

Are you pregnant? If yes, trimester:

MEDICAL CONDITIONS

Autoimmune Conditions:

Osteoporosis / Bone Density Treatment:

Bisphosphonates / Anti-resorptives:

Blood Thinners (Warfarin, DOACs):

Immunosuppressants / Steroids:

Sleep Apnoea / CPAP Use:

Diabetes:

Liver or Kidney Disease:

Epilepsy / Neurological Conditions:

History of Cancer or Radiotherapy:

Recent Hospitalisation:

ALLERGIES

Penicillin Allergy:

Latex Allergy:

Chlorhexidine Allergy:

Local Anaesthetic Allergy:

Aspirin / NSAID Allergy:

Food / Other Allergies:

Current Medications (List all):

CONSENT & GDPR

I consent / do not consent to clinical photographs being taken for:

- Educational purposes
- Professional training
- Treatment planning and clinical documentation

Photo Consent (Yes/No):

GDPR Acknowledgment:

I understand my information is confidential and may be used for clinical care, referrals, and appointment communication.

Consent to be contacted via:

Email: SMS:

Signature:

Date:

MOBILE DENTAL MEDICAL HISTORY FORM

Patient Name:

Date of Birth:

Contact Number:

Smoking Frequency:

Vaping / E-cigarette Use:

Blood Thinners (Warfarin, DOACs):

Bisphosphonates / Anti-resorptives:

Immunosuppressants / Steroids:

Sleep Apnoea / CPAP:

Allergies (Penicillin / Latex / Chlorhexidine / LA):

Current Medications:

Photo Consent (Educational Use) Yes/No:

Signature:

Date: