Confidential
Medical History Form

Great Western Hospitals NHS
NHS Foundation Trust
Community Dental Service

DOB: __/__/__
First Name:
Surname:

FOR OFFICE USE ONLY

We ask you for information about your general health to help us treat you safely. Please complete your contact details below and answer all the health questions and then sign the back of the form.
All information will be kept strictly confidential by our service.

Title:	Surname:	First name:
	Date of birth: _____ / _____ / _____	Sex: Male ☐ Female ☐
Address:		Postcode:
		Occupation:
Telephone number (home):		Mobile number:

In the event of an emergency, please contact

Name:
Telephone number:
Relationship to you:

Best interest contact

Name:
Telephone number:
Relationship to you:

Doctor's details

Doctor's name:	Telephone number:
Address:	Postcode:

Our dental chairs and hoist have a weight limit so for your safety we need to ask about your weight.

Do you weigh: Less than 21 stone? (133kg) ☐ Between 21 & 35 stone? (133–222kg) ☐ More than 35 stone? (222kg) ☐

Do you have: Hearing loss? ☐ Sight loss? ☐ Mobility problems? ☐

How many units of alcohol do you drink per week?
(a unit is half a pint of lager, a single measure of spirits or a small glass of wine) ..... units per week

Do you smoke tobacco products? Yes ☐ How many daily: No ☐ In the past ☐

Do you chew tobacco, pan or use gutkha? Yes ☐ No ☐ In the past ☐

Are you currently	**yes**	**no**	**give details**
Receiving treatment from a doctor, hospital or clinic?	☐	☐	
Taking any prescribed medicines? (including tablets, inhalers, injections, contraceptives and ointments) Please list in detail or additional sheet if required.	☐	☐	
Taking any self prescribed medicines/drugs? (including pain killers or recreational drugs)	☐	☐	
Carry a medical warning card or bracelet?	☐	☐	
Pregnant or possibly pregnant?	☐	☐	Date baby due:

Have you ever had	yes	no	give details
Allergies to drugs (eg penicillin, chlorhexidine), plasters, latex or food?	☐	☐	
Bronchitis/ Asthma/TB/ COPD or other chest condition?	☐	☐	
Epilepsy or other neurological disorder?	☐	☐	
Heart problems/ Angina/ High or Low blood pressure/ Stroke /Endocarditis/Valve disease or Heart surgery?	☐	☐	
Diabetes?	☐	☐	
Bone or joint disease? (eg osteo or inflammatory arthritis, osteoporosis etc)	☐	☐	
Persistent bleeding or bruising after injury, tooth extraction & surgery?	☐	☐	
Are you taking blood anticlotting drugs eg Warfarin or Prothrombin Inhibitor?	☐	☐	
Are you taking bisphosphonate medication (eg Alendronic Acid)?	☐	☐	
Liver disease?	☐	☐	
Kidney or urinary tract disease?	☐	☐	
Do you have/have you had infections Hepatitis B, Hepatitis C or HIV?	☐	☐	
Mental health problems? (e.g. Alzheimer's Disease, Dementia, Depression, Schizophrenia or Bipolar disorder)	☐	☐	
Learning disability?	☐	☐	
Drug or alcohol addiction?	☐	☐	
An operation under general anaesthetic in hospital?	☐	☐	
Other treatment that required you to be in hospital?	☐	☐	
Any other disabilities or conditions not listed above?	☐	☐	
A TEP or Resuscitation Decision Record in place	☐	☐	

Patient/Carer/Parent Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

Completed by *(please tick)* self ☐ parent ☐ guardian ☐

Medical history update

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

Name:	Date of birth: _____ / _____ / _____

Date	Any changes?	List changes below	Patient initials

Date	Any changes?	List changes below	Patient initials