Medical History Form

Surname .... **First Name(s)**..

Date of Birth .... **Title**.. **Sex M** ☐ **/ F** ☐

Home Address ....

.... **Phone No**..

If no telephone number is supplied then we may not be able to contact you if we need to cancel your appointment.

Email Address.. Please provide an email address if you would like check-up reminders. **Please tick your preferred method of contact :** Email ☐ Phone ☐ By Post ☐

Work Address ....

.... **Phone No** ....

Occupation ....

Family Doctor's Name & Address ....

.... **Phone No** ....

Hospital Doctor's Name & Address ....

.... **Phone No** ....

Question		Y	N
1. Do you experience chest pain upon exertion (angina)?	II	☐	☐
If so,		☐	☐
Have you had to reduce your activities?	III		
Have the complaints increased recently?	III	☐	☐
Do you have chest pain at rest?	IV	☐	☐
2. Have you ever had a heart attack?	II	☐	☐
If so,			
Do you still have complaints?	III	☐	☐
Have you had a heart attack in the last 6 months?	IV	☐	☐
3. Do you have a heart murmur or heart valve dysfunction or an artificial heart valve?	II	☐	☐
Have you had heart or vascular surgery within last 6 months?	III	☐	☐
Have you ever had rheumatic fever?	III	☐	☐
Have you ever had endocarditis?	IV	☐	☐
4. Do you have heart palpitations without exertion?	II	☐	☐
If so,			
Do you have to rest, sit down or lie down during palpitations?	III	☐	☐
Are you short of breath or pale or dizzy at these times?	IV	☐	☐
5. Do you have problems lying flat?	II	☐	☐
If so,			
Do you need more than 2 pillows at night due to shortness of breath?	III	☐	☐
6. Have you ever had high blood pressure?	II	☐	☐
7. Do you have a tendency to bleed after injury or surgery?	III	☐	☐
If so,			
Do you suffer from spontaneous bruising?	IV	☐	☐
8. Do you have epilepsy?	II	☐	☐
If so,			
Do you continue to have seizures?	III	☐	☐

Question		Y	N
9. Do you suffer from asthma?	II	☐	☐
If so,			
Do you use inhalers?	II	☐	☐
Is your breathing difficult today?	IV	☐	☐
Do you have a hayfever or eczema?	II	☐	☐
10. Do you have other lungs problems?	II	☐	☐
If so,			
Are you short of breath after climbing stairs?	III	☐	☐
Are you short of breath getting dressed?	IV	☐	☐
11. Do you have any allergies to any medicines (e. g. antibiotics), substances (e. g. latex/rubber) or foods?	II	☐	☐
If so, which ones			
12. Do you have diabetes?	II	☐	☐
If so,			
Are you on insulin?	II	☐	☐
Is your diabetes poorly controlled at present?	III	☐	☐
13. Do you suffer from thyroid disease?	II	☐	☐
If so,			
Is your thyroid gland overactive?	II	☐	☐
14. Do you suffer from liver disease?	II	☐	☐
If so,			
Have you had a liver transplant?	III	☐	☐
15. Do you have kidney disease?	II	☐	☐
If so,			
Are you undergoing haemodialysis?	III	☐	☐
Have you had any kidney transplant?	III	☐	☐
16. Have you ever had an operation?	II	☐	☐
If so,		☐	☐
Have you had a general anaesthetic or sedation?	II		
Were there any complications?	II	☐	☐
Have you had a joint replacement?	II	☐	☐

		Y	N
17. Have you ever had a malignant disease or leukaemia?	II	☐	☐
If so,			
Have you ever had chemotherapy or bone marrow transplant?	III	☐	☐
Have you ever had radiotherapy for a tumour or growth in the head or neck?	IV	☐	☐
18. Have you ever suffered from/are you suffering from an infectious disease (e. g. HIV, Hepatitis)?	II	☐	☐
If so, give details?	II	☐	☐
If so, when...			
20. Are you pregnant or trying to conceive?	II	☐	☐
21. Do you suffer from arthritis?	II	☐	☐
If so,			
Rheumatoid arthritis?	II	☐	☐
Osteo arthritis?	II	☐	☐

		Y	N
22. Have you ever had stroke?	II	☐	☐
23. Do you have any neurological disorders?	II	☐	☐
Multiple Sclerosis	II	☐	☐
Parkinson's Disease	II	☐	☐
Huntington's Chorea	II	☐	☐
Other..			
24. Do you drink alcohol?	II	☐	☐
If so,			
How many units per week?			
25. Do you smoke?	II	☐	☐
If so,			
What do you smoke?			
How many per day?			
26. Do you take any self – prescribed drugs?	II	☐	☐
If so, please detail below			

27. Are you/were you on medication?

	Y	N
for a heart complaint?	☐	☐
anticoagulants?	☐	☐
for high blood pressure?	☐	☐
aspirin or other pain – killers?	☐	☐
for an allergy?	☐	☐
for diabetes?	☐	☐
corticosteroids (systematic or topical)?	☐	☐
drugs against transplant rejection?	☐	☐
drugs against skin, bowel or rheumatic Diseases??	☐	☐
for cancer or blood disease?	☐	☐
penicillin, antibiotics or antmicrobials?	☐	☐
for sleeping disorder depressive condition or anxiety state?	☐	☐
have u ever used recreational drugs?	☐	☐
other medication (prescribed or otherwise)?	☐	☐

28. Please detail in this section, ANY drugs you have taken or currently taking.

Drug	Dose

Key Conditions

29. Are you in receipt of state benefits? If so, which one? ....

30. If you are new to the practice, how did you hear about us? ....

I HAVE COMPLETED THIS FORM AS ACCURATELY AS POSSIBLE. I UNDERSTAND THAT I NEED TO GIVE 24 HOURS NOTICE OF CANCELLATION OF APPOINTMENT. PAYMENT FOR EACH TREATMENT IS DUE AT EACH APPOINTMENT. ANY PAYMENTS NOT RECEIVED IN FULL COULD INCUR DEBT RECOVERY COSTS. **ALL FAILED PRIVATE AND HYGIENE APPOINTMENTS WILL BE CHARGED A FEE.**

Signed.. **Date**...

Dentist Name.. Dentist Signature...