

CONFIDENTIAL MEDICAL HISTORY FORM



COMBER
DENTAL
PRACTICE

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

Please complete this form and return it to the Receptionist. Print clearly.

TITLE	NAME
DATE OF BIRTH	SEX: MALE / FEMALE
EXPECTANT MOTHER: YES / NO	HOW LONG SINCE LAST RECEIVED DENTAL TREATMENT?
YOUR DOCTOR'S NAME & ADDRESS	

	YES	NO	DETAILS
1. Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?			
2. Are you taking any medicines from your doctor? (Tablets, creams, ointments, injections, other)			
3. Are you taking or have you taken steroids in the last two years?			
4. Are you taking or have you taken at any time in the past medication for osteoporosis?			
5. Are there any other aspects concerning your health that you think the dentist should know about?			

<i>Heart Conditions</i>	YES	NO	DETAILS	<i>Blood Conditions (cont)</i>	YES	NO	DETAILS
• Rheumatic Fever				• Blood Test			
• High Blood Pressure				• Sickle Cell			
• Heart Surgery				• Haemophilia			
• Pacemaker Fitted				• Other blood condition			
• Heart Murmur							
• Thrombosis				<i>Other Conditions</i>			
• Angina				• Serious Childhood Illness			
• Heart Attack				• Diabetes			
• Other heart condition(s)				• Liver Disease			
				• Kidney Disease			
<i>Chest Conditions</i>				• Epilepsy			
• Bronchitis				• Cancer			
• Emphysema				• Hiatus Hernia			
• Pneumonia				• Bad reaction to local anaesthetic			
• Chest Surgery				• Arthritis			
• Are you a smoker?				• Cold Sores			
• Cystic Fibrosis							
• Pleurisy				<i>Allergy Conditions</i>			
• Other chest condition(s)				• Penicillin			
				• Hay Fever			
<i>Blood Conditions</i>				• Eczema			
• Have you or your family bled so as to cause you to be worried?				• Aspirin			
• Hepatitis B or C				• Asthmatic			
• H.I.V.				• Other Allergy			
• Anaemia				• Latex Allergy			

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Completed by: Self/Patient/Guardian

Signature Date