Confidential Medical History **(Please ask if you need help to fill out this form or need it in larger font)**

We ask for information about your general health to help us treat you safely. All information will be kept strictly confidential by us, unless disclosure is necessary for the provision of safe and effective care and treatment when your consent will be needed.

Patient's Name DOB H&CNo: Landline/Mobile Phone No.	**Person to contact in event of emergency** Name Telephone No. Relationship to patient

Are you currently:	**No**	**Yes**	**If yes, give details**
Receiving treatment from your doctor, a hospital or clinic?			
Taking any **prescribed medicines or recreational/non-prescribed medicines** eg tablets, HRT, ointments, injections, inhalers, Heparins, Antiplatelets (eg. Aspirin, clopidogrel), bisphosphonates, Oral Anticoagulants (eg. Warfarin, apixaban)?			**A current list of medication from your GP must be provided**
If female – pregnant / possibly pregnant / breastfeeding?			
Carrying a medical warning card?			
Do you have:			**If yes, give details**
Any allergies to: **Medicines** (penicillin/aspirin/ibuprofen/local anaesthetic); **Substances** (latex/rubber); **Metals** (nickel); **Foods** (peanuts/kiwi)?			
Bronchitis, asthma or other chest complaint?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart disease or other heart problems eg angina / high or low blood pressure / stroke /a pace maker fitted, if so on which side / other?			
Diabetes (or does any immediate family member)?			
Bone or joint disease, Arthritis/Parkinsonism/Multiple Sclerosis/other			
A blood or bleeding disorder (eg persistent bleeding after injury, tooth extraction, surgery)?			
CJD or been notified that you are at increased risk of CJD or vCJD for public health purposes?			
Liver disease (eg. Jaundice, hepatitis), Kidney disease, any other serious illness or infectious disease (eg. TB, HepB, HepC or are HIV positive)?			
Have you ever had:			
Blood refused by the Blood Transfusion Service?			
A bad reaction to local anaesthetic?			
Alcohol & Tobacco Use (Would you be interested in attending our Smoking Cessation Clinic?)			
Do you currently (or did you) smoke any tobacco products or chew tobacco, betel quid, gutkha or paan?			Name of product: Daily Use: Now In Past:
How many units of alcohol do you regularly drink per week? (1unit = 10ml)			
Other:			
Sunbed use: If you use a sunbed, how many minutes per week?			
How can we help you? If you have a physical, sensory, learning or hidden disability, please let us have your suggestions as to how we can help you access our services.			
Completed & signed by: ○ **patient** ○ **patient's parent/guardian/carer** **Signature**			**Dentist:** **Signature** _____