CROWN HOUSE
DENTAL PRACTICE

MEDICAL HISTORY FORM

4 Grange Road, Egham, Surrey TW20 9QW, 01784 432641, www.crownhousedentalpractice.co.uk

To obtain the best and safest treatment for you, your dentist needs to know all aspects of your health which may affect your treatment. Please complete this form, which your dentist will discuss fully with you before commencing treatment. If you have any questions, please ask your dentist. Additional note may be written on the back cover. All information will be kept completely confidential. Thank you for your co-operation.

Patient Information:

- Male/Female
- Mr, Master, Mrs, Miss, Other
- Surname _____ First Name _____
- Date of Birth _____/_____/_____
- E-Mail Address _____
- Address

  _____

  _____Post Code_____
- NHS Number_____
- Home Number _____Mobile _____
- Occupation _____
- Name and Address of G.P

  _____

  _____Tel Num_____

Do You:

1. Attend or receive treatment from a doctor, hospital or clinic Y/N
2. Take any medication or drugs (injections, tablets, creams etc) Y/N

Please list:_____

_____

3. Take or have taken any steroids in the last 2 years Y/N
4. Have any allergies to any medicines, foods, or materials Y/N
5. Suffer from hay fever, eczema or any other allergy Y/N

_____

6. Suffer from bronchitis, shortness of breath or any chest conditions Y/N

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7. Have diabetes Y/N
8. Have fainting attacks, giddiness, blackouts or epilepsy Y/N

Have You Ever:

1. Had rheumatic fever or chorea (St Vitus' dance) Y/N
2. Had jaundice, liver disease or hepatitis Y/N
3. Had cause to think you are infected with TB. Hepatitas or HIV Y/N
4. Had a bad reaction to local or general anaesthetic Y/N
5. Bleed excessively following tooth extraction or injury Y/N
6. Had any serious illness, disabilities or operations Y/N

_____

7. Had any treatment for cancer related illnesses Y/N
8. Do you have a pacemaker or have you had any form of heart surgery Y/N
9. Do you have any disease, condition or problems not listed that you think your dentist should know about Y/N

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- Do you carry a warning card or bracelet Y/N
- Do you smoke Y/N If yes, how many per day_____
- Do you drink Y/N If yes, how many units per day/week_____

Women Only:

- Are you pregnant Y/N
- Are you breastfeeding Y/N
- Do you take the contraceptive pill Y/N

Please circle your preferred method of contact **E-Mail / Telephone / Letter / All**

Signed_____

Completed By: Self / Parent / Guardian **Signed _____**