

# Confidential Medical History

Great Wyrley Dental Practice

2 Southfield Way

Great Wyrley

Walsall

WS6 6JZ

Forename:

Home Tel:

Surname:

Mobile Tel:

D.O.B.:

Email Address:

<b>Lifestyle</b>	<input type="checkbox"/>	Smokes (per day)	<input type="checkbox"/>	High sugar/frequency	
	<input type="checkbox"/>	Chews (per day)	<input type="checkbox"/>	Lots fizzy/acidic drinks	
	<input type="checkbox"/>	Alcohol (units per week)	<input type="checkbox"/>	Recreational drugs	
	<input type="checkbox"/>	Pregnant or possibly pregnant	<input type="checkbox"/>	Anything else	
<b>Heart</b>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Heart Murmur	
	<input type="checkbox"/>	High / Low Blood Pressure	<input type="checkbox"/>	Angina	
	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	Thrombosis	
	<input type="checkbox"/>	Pacemaker Fitted	<input type="checkbox"/>	Other Heart Condition	
<b>Blood</b>	<input type="checkbox"/>	Hepatitis A,B,C,D	<input type="checkbox"/>	Anaemia	
	<input type="checkbox"/>	H.I.V. / AIDS	<input type="checkbox"/>	Sickle Cell	
	<input type="checkbox"/>	Abnormal Blood Test Result	<input type="checkbox"/>	Haemophilia	
	<input type="checkbox"/>	Blood refused by transfusion svce.	<input type="checkbox"/>	Other Blood Condition	
<b>Allergies</b>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	Latex Allergy	
	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Medicines	
	<input type="checkbox"/>	Anti-Tetanus Serum	<input type="checkbox"/>	Plants	
	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Foods	
	<input type="checkbox"/>	General Anaesthetic	<input type="checkbox"/>	Aspirin	
	<input type="checkbox"/>	Local Anaesthetic	<input type="checkbox"/>	Other Allergy	
<b>Warnings</b>	<input type="checkbox"/>	Hearing or Sight Impairment	<input type="checkbox"/>	Do not recline	
	<input type="checkbox"/>	Antibiotic cover required	<input type="checkbox"/>	Steroids in last 2 years	
	<input type="checkbox"/>	Bruising or persistent bleeding	<input type="checkbox"/>	Warning Card	
	<input type="checkbox"/>	Currently under treatment	<input type="checkbox"/>	Required Hospitalisation	
<b>Chest</b>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Emphysema	
	<input type="checkbox"/>	Cystic Fibrosis	<input type="checkbox"/>	Pneumonia	
	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	Chest Surgery	
	<input type="checkbox"/>	Asthmatic	<input type="checkbox"/>	Other Chest Condition	
<b>Medication</b>					
<b>Other</b>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Kidney Disease	
	<input type="checkbox"/>	Diabetes / Family with Diabetes	<input type="checkbox"/>	Epilepsy	
	<input type="checkbox"/>	Acid Reflux or Eating Disorder	<input type="checkbox"/>	Hiatus Hernia	
	<input type="checkbox"/>	Bone or Joint Disease	<input type="checkbox"/>	Artificial joint	
	<input type="checkbox"/>	Fainting Attacks or Blackouts	<input type="checkbox"/>	Giddiness	
	<input type="checkbox"/>	Past serious or infectious disease	<input type="checkbox"/>	Cancer / Radiotherapy	
	<input type="checkbox"/>	Depressive Illness	<input type="checkbox"/>	Stroke	
	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	Tuberculosis	
	<input type="checkbox"/>	Severe Headaches	<input type="checkbox"/>	Cold Sores	

Doctor's Name:

Emergency Contact:

Practice Phone:

Contact Number:

Practice Name:

Relationship:

Signature:

(Patient, Parent,  
Guardian or Carer)

Date: