Confidential Medical History

Smilecraft Dental Care

Name: DOB:

Address: Email:

Home Phone: Mobile:

Name of Doctor: Practice Name: Practice Phone:	Emergency Contact: Emergency Contact Phone: Relationship:

Lifestyle		Smoke tobacco products? (Per day)		High sugar/ frequency	Details:
		Chew tobacco, pan, gutka, supari (Per day)		Lots fizzy/acidic drinks	
		Consume alcohol? (units per week)		Recreational drugs	
		Anything else the dentist should know		Pregnant (possibly)	
Heart		Rheumatic Fever		Heart Murmur	Details:
		High/Low Blood Pressure		Angina	
		Heart Surgery		Thrombosis	
		Pacemaker Fitted		Other Heart conditions	
Blood		Hepatitis A, B, C, D		Anaemia	Details:
		H.I.V. / AIDS		Sickle Cell	
		Abnormal Blood Test Result		Haemophilia	
		Blood refused by transfusion service		Other Blood conditions	
Allergies		Penicillin		Latex	Details:
		Hay Fever		Medicines	
		Anti-Tetanus Serum		Plants	
		Eczema		Foods	
		Reaction to General Anaesthetic		Aspirin	
		Reaction to Local Anaesthetic		Other Allergy	
Warnings		Hearing/Sight Impairment		Problem being reclined	Details:
		Antibiotic Cover required		Steroids in last 2 years	
		Any treatment that required a hospital		Warning Card	
		Bruising or persistent bleeding after injury, surgery or tooth extraction			
		Currently under treatment of a doctor, hospital or clinic			
Chest		Bronchitis		Emphysema	Details:
		Cystic Fibrosis		Pneumonia	
		Pleurisy		Chest Surgery	
		Asthma		Other Chest Conditions	

Medication	List and state doses for any prescribed medicines, tablets, ointments, injections or inhalers (inc. contraceptives and HRT) you are taking:

Other		Liver Disease (e.g. jaundice)		Kidney Disease	Details:
		Diabetes / Family with Diabetes		Epilepsy	
		Acid Reflux or Eating disorder		Hiatus Hernia	
		Bone or Joint disease		Artificial Joint	
		Fainting Attacks or Blackouts		Giddiness	
		Any past Serious or Infectious disease		Cancer / Radiotherapy	
		Depressive Illness		Stroke	
		Nervous Problems		Tuberculosis	
		Severe Headaches		Cold Sores	

Signed by: …….. Date: