WATERCRESS
House Dental & Implant Clinic

CONFIDENTIAL MEDICAL HISTORY SHEET

We ask you for information about your general health to help us treat you safely.
Please write your contact details below, answer the health questions
and then sign the form on the back page.
We will use this form at later visits to discuss any changes in your general health.
All information will be kept strictly confidential by the people caring for you.

Patient details

Surname ..... **Title**.....

Forenames .....

Sex ☐ Male | ☐ Female **Date of birth** day..... month.....year.....

Address .....

City ..... **Postcode** .....

Telephone home ..... work .....

Email .....

Occupation .....

Relevant hobbies/sport (e.g. sport contact, playing a mouth instrument, public speech)

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Date of last dental treatment day ..... month ..... year .....

Doctor's name .....

Doctor's address .....

Doctor's telephone .....

Emergency contact .....

Are you currently	Yes	No	Give details
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?			
Taking bisphosphonate			
Carrying a medical warning card?			
Pregnant			

Do you soffer from	Yes	No	Give details
Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?			
Hay fever or eczema?			
Bronchitis, asthma or other chest condition?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart problems, angina, blood pressure problems, or stroke?			
Diabetes (or does anyone in your family)?			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases (including HIV and hepatitis)?			

Did you, as a child or since, have	Yes	No	Give details
Rheumatic fever or chorea?			
Liver disease (e.g. jaundice, hepatitis) or kidney disease?			
Any other serious illness?			
Blood refused by the Blood Transfusion Service?			
A bad reaction to general or local anaesthetic?			
A joint replacement or other implant?			
Treatment that required you to be in the hospital?			
Heart surgery?			

Drinking	Units / Week
How many units of alcohol do you drink per week? (A unit is half a pint of lager, a single measure of spirits or a small single glass of wine/aperitif).	*Units per week*

Smoking and Chewing	Yes	No	In past	What ? (e.g. cigar, cigarette without filter)	Quantity
Do you smoke any tobacco products now (or did you in the past)?					*Times for day*
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)?					*Times for day*

Please give any other details which your dentist might need to know about, such as self-prescribed medicines (eg aspirin)

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Completed by *(please tick)* Self☐ Parent☐ Guardian☐

SIGNATURE .....

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below).

Date	No change	Change	Patient's intials

Additional notes