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

Other - please state _____

I confirm that I have read practice privacy policy and I agree to the same
http://www.portreedentalcare.co.uk/privacy-policy/

Patient signature _____ Date _____

Dentist signature _____ Date _____

Medical history update

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	Any changes?	List changes below	Patient initials

Confidential
Medical History Form

Let's Smile with Portree Dental Care

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 change in you general health. All information will be kept strictly confidential by the people caring for you.

Title: | Last name:

Prefered name: | First name:

Date of birth: ___ / ___ / ____ | Sex Male ☐ Female ☐

NHS Number:

Address:

Postcode:

Telephone number (home):

Mobile number: | Occupation:

Email:

in the event of an emergency, please contact

Name:

Telephone number: | Relationship to you:

Doctor's details

Doctor's name: | Telephone number:

Address:

Postcode:

Are you currently	Yes / no	Please give details
Receiving treatment from a doctor, hospital or clinic?	☐ ☐	
Taking any prescribed medicines (e.g. Warfarin, bisphosphonates, or other tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?	☐ ☐	
Carrying a medical warning card?	☐ ☐	
Pregnant or possibly pregnant	☐ ☐	

Have you ever had	Yes / no	Please give details
Allergies to medicines (eg penicillin), substances (eg latex/rubber) or foods?	☐ ☐	
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)?	☐ ☐	
Bone or joint disease?	☐ ☐	
Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐ ☐	
Liver disease (eg jaundice, hepatitis) or kindney disease?	☐ ☐	
Any other serious illness or infectious disease?	☐ ☐	

Have you ever had	yes / no	please give details
Blood refused by the Blood Transfusion Service or any other agency abroad?	☐ ☐	
A bad reaction to general or local anaesthetic?	☐ ☐	
Treatment that required you to be in hospital?	☐ ☐	
Heart surgery or a stent?	☐ ☐	
Any form of mental illness (e.g.) Depression, anxiety, stress, eating disorders)?	☐ ☐	

Alcohol	Please give details
How would you describe you consumption of alcohol? Non-drinker, modest, moderate, more than is probably good for me, heavy?	

Smoking	yes / no in the past	
Do you smoke any tobacco products now (or did you in the past)?	☐ ☐ ☐	_____times per day
Do you chew tobacco, pan, use gutkha, supari, or betel now (or did you in the past)?	☐ ☐ ☐	_____times per day
Do you vape/use electronic cigarettes? (Or did you in the past)?	☐ ☐ ☐	_____times per day

Please give any other details which your dentist might need to know about, such as self-prescribed medicines (eg aspirin) or any disabilities or health concerns you may have.