THE Northumberland Institute OF DENTAL MEDICINE

CONFIDENTIAL MEDICAL HISTORY FORM

Title:	**Firstname:**	**Surname:**
Date of Birth:	Sex (Male/Female):	Occupation:
Tel (Home):	(Work):	(Mobile):
Address:		
Email:	Insurance cover (VHI Decare etc):	
Referred/Recommended by:	Preferred Contact Method (Email/Post):	
GP Name & Address:		
Dentist Name & Address:		
Next of Kin: Name	Tel:	Relationship:

	Yes	No	If yes, please detail
1. Are you attending a doctor for any specific complaint?			
2. Are you taking any medications at present? e.g. aspirin, anti-coagulants, contraceptive pill, osteoporosis medication			
3. If female, are you pregnant?			*Expected due date?*
4. Have you ever taken long-term steroids or immunosuppressive drugs?			
5. Have you ever been hospitalised?			
6. Have you ever had an adverse reaction to general or local anaesthetic or sedation?			
7. Have you ever had excessive bleeding or bruising following a tooth extraction or cut?			

Have you ever had:	Yes	No	If yes, please detail

8. Heart complaint e.g. Angina (chest pain), attack, murmur, surgery

9. High blood pressure

10. Deep vein thrombosis (DVT) or clot

11. Radiation therapy or chemotherapy

12. Jaundice, liver or kidney disease

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Do you suffer from:	**Yes**	**No**	**If yes, please detail**
13. Anemia			
14. Arthritis, osteoporosis or joint condition			
15. Asthma, bronchitis or chest condition			
16. Allergies e.g. Penicillin, latex, any medication			
17. Cold sores			
18. Diabetes			*What type? Since when?*
19. Epilepsy or Fainting			

20. Hepatitis or any blood-borne virus	
21. Stomach ulcer or stomach condition	
22. Thyroid disease	

Do you:	**Yes**	**No**	**If yes, please detail**
23. Smoke			*How many per day? Since when?*
24. Drink Alcohol			*How much per week?*

	Yes	**No**	**If yes, please detail**
25. Are there any other aspects concerning your health that you think your oral surgeon should know about?			
26. Do you carry a warning card?			

Would you like to be contacted in the future about our practice newsletter?

I, the undersigned, certify that to the best of my knowledge, the information provided on this medical history form is correct. I understand that the information provided here will be kept strictly confidential and will not be made publicly available without my consent.

Completion Date: **Completed by:**

If you have any queries regarding the health or aesthetics of your smile, we would be happy to discuss these during your consultation.