Dr. Neel Tank & Associates
imogendental
imogendental.co.uk

North Street, Kingsclere, Berkshire. RG20 5QX
0844 5769339

14 High Street, Benson, Oxon. OX10 6RP
01491 833380

CONFIDENTIAL MEDICAL HISTORY FORM

We ask you for information about your general health to help us treat you safely. Please complete and sign this form which will be used at later visits to discuss any changes in your general health. All information will be kept strictly confidential by the people caring for you.

Title: First Name: Last Name: DoB:

Address:

Postcode:

Tel. Home: Mobile:

Business: Email:

Occupation:

National Insurance No: NHS Medical Number:

How did you hear about the practice?

In the event of an emergency please contact

Name: Tel: Relationship:

Doctor's details

Name: Tel No:

Address: Postcode:

ARE YOU CURRENTLY

Receiving treatment from a doctor, hospital or clinic Yes ☐ No ☐

Carrying a Medical Warning Card? Yes ☐ No ☐

Heart problems, angina, blood pressure, stroke heart surgery Yes ☐ No ☐

Bronchitis, asthma or other chest conditions? Yes ☐ No ☐

Diabetes (or anyone in your family) Yes ☐ No ☐

Have you ever suffered from Allergies to medicines (eg penicillin) or substances (eg rubber/latex) or foods? Yes ☐ No ☐

Bruising or persistent bleeding following Injury, tooth extraction or surgery? Yes ☐ No ☐

Bone, joint disease or replacement? Yes ☐ No ☐

Pregnant or possibly pregnant? Yes ☐ No ☐

Liver disease (eg Jaundice, hepatitis) or Kidney Disease Yes ☐ No ☐

Any other serious illness or infectious disease? Yes ☐ No ☐

Have you ever had blood refused by the Blood Transfusion Service. Yes ☐ No ☐

Diagnosed with HIV? Yes ☐ No ☐

Fainting attacks, giddiness, blackouts, epilepsy? Yes ☐ No ☐

Undergone an operation in the last 2 years Yes ☐ No ☐

Had a bad reaction to general or local anaesthetic Yes ☐ No ☐

Do you weigh over 25 stone? Yes ☐ No ☐

ALCOHOL

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 single glass of wine) Units per week _____

SMOKING

Do you smoke any tobacco products now or in the past? Per day _____ Yes ☐ No ☐

Taking any prescribed medicines (eg tablets, ointments, Injections or inhalers including contraceptives, HRT) Hydro-cortisone or Corticosteroids. Yes ☐ No ☐

Medication list/further details:

_____

_____

_____

_____

If any of the above medical circumstances change, please inform your Dentist.

DECLARATION: I understand the medical questions and have answered them to the best of my ability.

Completed by: _____ parent/guardian

Signature: _____

Patient's signature: _____

Date: _____

Dentist's signature: _____

Date: _____