Hudson'sDental
Healthy Teeth, Beautiful Smiles

CONTENTS STRICTLY CONFIDENTIAL
This form will be scanned to your secure computerised records & then shredded to protect & ensure patient confidentiality.

CONFIDENTIAL Medical History Form

Title : .... Forename:.. Surname : ....

Address : ....

Postcode : .... D.O.B. : ....

Home Tel : .... Work Tel : ....

Mobile Tel : .... Occupation : ....

Email : ....

Doctor's Name & Surgery : ....

Are You Currently :	**Yes**	**No**	**Please Give Details :**
Pregnant?			
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines? (e.g. Tablets, ointments, injections, inhalers, contraceptives or HRT.)			
Carrying a medical card?			
Do you suffer from :	**Yes**	**No**	**Please Give Details :**
Hayfever or eczema?			
Allergies to any medicines (e.g. Penicillin) substances (e,g, latex or rubber) or foods?			
Bronchitis, asthma or other chest conditions?			
Fainting attacks, giddiness, blackouts or epilepsy?			
Heart problems, angina, blood pressure problems or stroke?			
Diabetes?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases? (including HIV & Hepatitis.)			

PLEASE TURN OVER

Did you as a child or since have :	Yes	No	Please Give Details :
Blood refused by the blood transfusion service?			
A bad reaction to a general or local ananesthetic?			
Treatment that required you to be in hospital?			
A joint replacement or other implant?			
Heart Surgery?			
Brain Surgery?			
A close relative with creutzfeldt jakob disease?			
Growth hormone treatment before the mid-1980's?			
Drinking :	**Yes**	**No**	**If yes how many units a week?**
Do you drink alcohol?			
Smoking & Chewing :	**Yes**	**No**	**If yes how many a day?**
Do you smoke?			
If no, did you smoke in the past?			
Do you chew tobacco, pan, use gutkha or supari?			
If no, did you chew tobacco, pan, use gutkha or supari in the past?			

Please give any details that you think your dentist might need to know :

Signature : .... **Date :** ....

Completed by (Please tick) :	
Myself :	
Parent :	
Guardian :	