The

DENTURE SPA

Medical History Form

CONFIDENTIAL

Please provide us with information about your personal details and general health to help us treat you safely. Do not answer any questions you do not understand. You will have the opportunity to discuss any queries with your dentist who will be happy to answer any of your questions.

All information will be kept strictly confidential by the people caring for you.

Patient details: (BLOCK CAPITAL LETTERS PLEASE)

Title: (Mr/Mrs/Ms/Miss) Sex: (Male/Female) Date of Birth: ☐☐/☐☐/☐☐

First Name:

Surname: Email:

Address:

Town: Postcode (ESSENTIAL):

NHS Number: Occupation:

Telephone (DAYTIME): Telephone (MOBILE):

Please **tick** if you would like to receive information about our services, products and information which we feel might be of interest to you by:

Post: ☐ Email: ☐ Telephone: ☐ Text: ☐

Next of Kin: (BLOCK CAPITAL LETTERS PLEASE)

Title: (Mr/Mrs/Ms/Miss) Date of Birth: ☐☐/☐☐/☐☐

First Name:

Surname: Relationship to You:

Address:

Town: Postcode (ESSENTIAL):

Telephone (DAYTIME): Telephone (MOBILE):

By completing this section you consent to the practice contacting your next of kin in the event of a medical emergency:

When did you last visit a dentist?:

Doctor's Name and Address:

Doctor's Telephone:

Please tick all that apply and list any details in the notes field provided.

Are you currently	Yes	No
Pregnant?	☐	☐
Receiving treatment from a doctor, hospital or clinic?	☐	☐
Taking any prescribed medicines (e.g. tablets, ointments, injections, or inhalers, eyedrops, suppositories, nebulisers, the contraceptive pill or HRT)?	☐	☐
Carrying a medical warning card? Details:	☐	☐

Details:

Do you suffer from.	Yes	No
Allergies to any medicines (e.g. penicillin), substances (e.g. latex/rubber or foods)?	☐	☐
Hay fever or eczema?	☐	☐
Bronchitis, asthma or other chest condition?	☐	☐
Fainting attacks, giddiness, blackouts, epilepsy?	☐	☐
Muscle problems (e.g. myopathy, dystrophy, paralysis)?	☐	☐
Heart problems (e.g. angina, blood pressure problems or stroke)?	☐	☐
Diabetes (or does anyone in your family)?	☐	☐
Neurological (nerve) diseases (e.g. 'neuropathies', MS etc.)?	☐	☐
Arthritis?	☐	☐
Bruising or persistent bleeding following injury, tooth extraction or surgery? Any infectious diseases (including HIV, hepatitis, TB)?	☐	☐
Stomach ulcers/hiatus hernia/indigestion?	☐	☐

Details:

Have you a child or since, suffered with.	Yes	No
Rheumatic fever, heart murmur or chorea?	☐	☐
Liver disease (e.g. jaundice, hepatitis)?	☐	☐
Kidney disease?	☐	☐
Any other serious illness?	☐	☐

Details:

Have you a child or since, suffered with.	Yes	No
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 hospital? Heart surgery?	☐	☐
Brain surgery?	☐	☐
Growth hormone treatment before the mid 1980s?	☐	☐
A close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease (CJD)?	☐	☐
Steroid treatment?	☐	☐

Details:

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/aperitif)

Units per week? ☐

Smoking and Chewing.	Yes	No	In The Past
Do you smoke any tobacco products now (or did you in the past)? How many times per day? ☐	☐	☐	☐
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)? How many times per day? ☐	☐	☐	☐

Please give any other details which your clinician might need to know about, such as self-prescribed medicines (e.g. aspirin). Including herbal remedies.

Date:

Please list of any changes in relation to alcohol consumption, smoking and chewing:

Alcohol units p/w: ☐ Smoking time p/d: ☐ Patient Initials: ☐ Clinician Initials: ☐

Finally, just for fun. What three things do you like to do in your spare time?

1: ☐ 2: ☐ 3: ☐

Favourite film or TV show? ☐ Favourite band/artist? ☐

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

Signature: Clinicians Signature: Date:

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