Guildford orthodontics

PATIENT MEDICAL HISTORY SHEET - CONFIDENTIAL

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 may use this form at later visits to discuss any changes in your general health.

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

Patient Title			Patient Surname			
Patient Forename/s			**If you are the Parent/Guardian of this patient and hold full responsibility, please also complete the Responsible Party Information below. However, if you are the patient, please ignore**			
Patient Sex	Male	Female	Date of Birth	DD	MM	YYYY
Address Postcode						
Mobile	*Home*	*Work*				
*E-mail**						

**Please be aware in providing an e-mail address you consent to receiving communications regarding appointments and treatment at the practice for the patient*

Name of current Dentist	

Doctor's name	
Doctor's address *inc postcode*	
Doctor's telephone	
NHS Number *In the event of a specialist NHS referral this information is required*	

Parent/Guardian Information					
Title	Forename	Surname			
Full Address *if different from above* Postcode					
*Mobile**	*Home**	*Work*			
Relationship to patient					
Is this individual financially responsible for charges? *ie breakages, sundries and repairs*			Y	N	
Does this individual bring the patient to appointments?			Y	N	

****Please sign in this box if you consent for messages to be left on the numbers stated, with voicemail, regarding treatment and appointment changes for the patient***

Name:……Date:……Signature:……

Please turn over

Is the patient currently	Y	N	Give details
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?			
Carrying a medical warning card?			
Pregnant			

Does the patient suffer from	Y	N	Give details
Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?			
Hay fever or eczema?			
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)?			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases (including HIV and hepatitis)?			

Did the patient, as a child or since, have:	Y	N	Give details
Rheumatic fever or chorea?			
Liver disease (e.g. jaundice, hepatitis) or kidney disease?			
Any other serious illness?			
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 the hospital?			
Heart surgery?			

Drinking	Quantity
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	Y	N	In Past	Quantity
Do you smoke any tobacco products now (or did you in the past)?				*times per day*
Do you chew tobacco, pan, use gutkha or supari now (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)

Please advise us if your child suffers with any of the following conditions:
Autism/ADHD/Any learning difficulties *(please state):*

SIGNATURE……DATE…….

Please indicate: Self / Parent / Guardian

Please ensure you update staff with any updates to information above at future visits