**MEDICAL HISTORY FORM (CONFIDENTIAL)**

Welcome to Western Dental. To obtain the best and safest treatment, your dentist needs to know of any problems which may affect your treatment.

**Patient Information**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PPS No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male Female**

**Tel No. Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you have health insurance? Yes No

Do you have a medical card? Yes No

**Your Doctor’s Name and Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How long has it been since you last received dental treatment?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had dental treatment abroad or elsewhere since last seen here? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please answer YES or NO to the questions below:**

1. Have you ever had **rheumatic fever** or chorea (St. Vitus’ dance)?
2. Do you have **heart trouble**, heart **murmur or angina** or have you had a **stroke or heart attack**?
3. Do you have a **pacemaker,** or have you had any form of **heart surgery or valve replacement?**
4. Do you have **high or low** **blood pressure**? ***(Please circle)***
5. Have you had **jaundice, liver, kidney disease** or **hepatitis**?
6. Have you ever had severe **bleeding** that needed special treatment (such as admission to hospital or blood transfusions) after extractions, surgery, injury or dental treatment?
7. Are you taking any **tablets, pills, medicines, drugs, skin creams, ointments, inhalers or injections**? Are you taking **bisphosphonates**? **(if YES, please list)**
8. Do you suffer from **asthma, hay-fever, eczema** or **other allergies?**
9. Are you **allergic** to **penicillin** or any other **antibiotic, drug, food** or **substance** (e.g. pollen, rubber, latex, metals)?
10. Are you diabetic**?**
11. Do you have **epilepsy** or suffer from giddiness, blackouts or fainting?
12. Have you had any **serious illnesses** or **operations**?
13. How often do you: **Smoke: Drink:**
14. Are you **pregnant**?

If **YES** when is your baby expected?

1. Are you under the care of a **doctor, consultant, hospital or clinic** now or have you been within the last two years?
2. Have you had a joint replacement?
3. Have you ever had surgery for a growth anywhere on your body?
4. Do you have arthritis?
5. Do you carry a warning card?
6. Are you in a risk group for blood borne viral infections i.e. Hepatitis B/Hepatitis C/H.I.V. Aids, or have you had blood refused by the blood transfusion service?
7. Do you have any chest problems e.g. bronchitis, T.B.?
8. Do you bruise easily or bleed excessively?
9. Do you suffer or have you ever suffered with panic attacks, anxiety disorders, or depression, which required you to seek advice from a healthcare professional.
10. Have you been treated or hospitalised for mental illness, and /or psychoses.
11. If you have visited us before, have there been any changes in your health, medicines or tablets since your last visit?

*Please add any additional details that you might want the dentist to know about:*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Children’s Consent Form**:

I consent to the dental examination of my child.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian

**To be completed after examination**

I consent to the dental treatment of my child. I understand what the treatment entails, and it has been explained to me by dental surgery staff.

I also consent to alternative operative procedures as may be found necessary during the course of the treatment and to the administration of local anaesthetic.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_