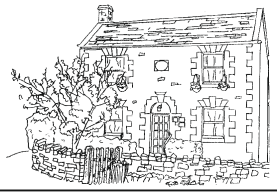
MILLER & ISAACS AT
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# CONFIDENTIAL MEDICAL HISTORY FORM

Title: _____ First Name: _____ Surname: _____ Date of Birth: _____

Address: _____

_____ Postcode: _____

Telephone: **Home** _____ **Work** _____ **Mobile** _____

**Email** _____ Occupation: _____

GP Name & Surgery: _____ NHS Number: ☐☐☐ ☐☐☐ ☐☐☐☐

Next of Kin (in case of emergency): _____ Telephone: _____

**PLEASE ANSWER EVERY QUESTION AND TICK THE CORRECT ANSWER**

| | | | |
|---|---|---|---|
| 1. | Are you allergic to PENICILLIN? | YES | NO |
| 2. | Have you ever had RHEUMATIC FEVER or been told you have a HEART MURMUR? | YES | NO |
| 3. | Do you have a LATEX allergy? | YES | NO |
| 4. | Do you take WARFARIN or any other ANTICOAGULANT? | YES | NO |
| 5. | Are you ALLERGIC to any OTHER MEDICATION? (If yes, please detail overleaf) | YES | NO |
| 6. | Do you regularly take aspirin or any similar medication? | YES | NO |
| 7. | Have you ever had ill effects following dental treatment? | YES | NO |
| 8. | Have you or any relation ever had any severe PROLONGED BLEEDING PROBLEMS? | YES | NO |
| 9. | Do you have HIGH BLOOD PRESSURE? | YES | NO |
| 10. | Have you ever had serious BLEEDING PROBLEMS following an EXTRACTION? | YES | NO |
| 11. | Have you ever had BLOOD TRANSFUSIONS? | YES | NO |
| 12. | Do you have any BLOOD DISORDERS? | YES | NO |
| 13. | Are you under medical care or TAKING ANY MEDICATION? (If so, please list any tablet/medication overleaf) | YES | NO |
| 14. | Have you ever had any PROLONGED ILLNESS or HOSPITALISATION? (If so, please list what for overleaf) | YES | NO |
| 15. | Do you have CONGENITAL HEART LESION/PACEMAKER? (If yes, please state which) | YES | NO |
| 16. | Do you have DIABETES? | YES | NO |
| 17. | Do you have HIATUS HERNIA/STOMACH TROUBLE? | YES | NO |
| 18. | Do you have EPILEPSY? | YES | NO |
| 19. | Do you have KIDNEY PROBLEMS? | YES | NO |
| 20. | Have you had a HEART ATTACK/ANGINA? (if yes, please state which) | YES | NO |
| 21. | Have you ever had JAUNDICE, INFECTIVE HEPATITIS, LIVER DISEASE? | YES | NO |
| 22. | Have you ever had TUBERCULOSIS? | YES | NO |

PLEASE TURN OVER

23. Have you ever had RADIO THERAPY? ..... YES NO

24. Have you had CHEMO THERAPY? ..... YES NO

25. Do you suffer from HAY FEVER? ..... YES NO

26. Do you suffer from ASTHMA or any other chest problems? ..... YES NO

27. Have you ever had ILL EFFECTS FROM LOCAL ANAESTHETIC? ..... YES NO

28. Do you smoke? If yes, please specify: Cannabis [ ] Tobacco [ ] E-Cigarettes [ ] ..... YES NO

29. Have you previously smoked? If yes, please specify: How long? [ ] Average per day [ ] ..... YES NO

30. Have you ever suffered from an eating disorder? ..... YES NO

31. On exertion do you have CHEST PAINS, SHORTNESS OF BREATH OR PALPITATIONS? ..... YES NO

32. Are you HIV positive? ..... YES NO

33. Are you taking oral contraceptives? ..... YES NO

34. Are you PREGNANT? If yes, estimated due date [ DAY / MONTH / YEAR ] ..... YES NO

35. What is your average units of alcohol? [ ] per week

36. Do you consent for us to discuss your dental treatment with a family member/friend? YES NO
If yes, please provide contact details:

Name ..... Telephone Number .....

37. Is there any OTHER INFORMATION about your MEDICAL or DENTAL HISTORY that may be important? ..... YES NO

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Please use the space below to provide any additional information.

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At Miller & Isaacs Dental Surgery, we take great care with all Personal Data we hold, to ensure we comply with best professional practice and the law.
For a full copy of our Data Privacy Notice please see our website or our waiting room notice board.

Please sign below:

Signature ..... Date ..... / ..... / .....

Signature ..... Date ..... / ..... / .....

Signature ..... Date ..... / ..... / .....

Signature ..... Date ..... / ..... / .....

Signature ..... Date ..... / ..... / .....

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Signature ..... Date ..... / ..... / .....