Confidential Medical History Form

A number of medical conditions can affect your dental treatment. To provide you with the safest treatment, your dentist needs to know the answers to the following:

Charisma Clinic

DENTISTRY & FACIAL AESTHETICS

Title:	Full Name:	D.O.B:
Male ☐	Address:	
Female ☐		Postcode:
Tel (home):	Email:	
Tel (work):	Occupation:	
Tel (mobile):	How did you find out about us?	
Your Doctor's name & address:		

Please answer the following questions as best you can:	YES	NO	Please give details:
Receiving treatment from a Doctor, Hospital or Clinic?	☐	☐	
Taking any prescribed medicines?	☐	☐	
Carrying a medical warning card?	☐	☐	
Pregnant?	☐	☐	
Allergies to any medicines, substances or food?	☐	☐	
Hay fever or eczema?	☐	☐	
Bronchitis, asthma or other chest conditions?	☐	☐	
Fainting attacks, giddiness, blackouts or 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?	☐	☐	

Please continue and sign on Page 2

Please answer the following questions as best you can:	YES	NO	Please give details:
Any infectious diseases?	☐	☐	
Rheumatic fever or chorea?	☐	☐	
Liver disease or kidney disease?	☐	☐	
Any other serious illness?	☐	☐	
Blood refused by 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?	☐	☐	
Do you smoke tobacco products now (or in the past)?	☐	☐	
Do you chew tobacco, pan, use gutkha, or supari now (or in the past)?	☐	☐	
Do you regularly drink alcohol (if so what is your average weekly consumption)?	☐	☐	

Please give any details that your dentist may need to know, such as homeopathic remedies, self-prescribed medicines (eg. aspirin) or any other aspects of your health:

By signing this Medical History Form you consent to the disclosure of your dental notes and other records for the purpose of any review, assessment or consideration of the care provided by your dentist, which may take place in the fulfilment of the 'Charisma Clinic' Clinical Governance Policy; but not for any other purpose without further consent.

Completed by: Self/Parent/Guardian/On behalf of Patient:

Signature: Print Name: Date: / /

Medical History Update (to be signed only in the presence of the dentist)

Have there been any changes in your health, medicines, injections or tablets since your last examination?

YES ☐ NO ☐ Signature: Date: / /

YES ☐ NO ☐ Signature: Date: / /

YES ☐ NO ☐ Signature: Date: / /

YES ☐ NO ☐ Signature: Date: / /

YES ☐ NO ☐ Signature: Date: / /