CONFIDENTIAL
MEDICAL HISTORY FORM

Title (Mr/Mrs/Ms/Others) ..... Surname .....

First name(s) .....

Age ..... Date of Birth ..... Occupation .....

Home address .....

.....

Telephone No: Home ..... Business .....

Mobile ..... Email .....

How did you hear about us? ☐ Word of mouth ☐ Received leaflet ☐ Advert

☐ Passed by the practice ☐ Other .....

1. Are you at present in good medical health? ☐ Yes ☐ No
2. Have you received any medical treatment in the last two years? ☐ Yes ☐ No

   If yes, please describe .....

.....

3. Are you taking any tablets or pills? ☐ Yes ☐ No

   If yes, please give details .....

4. Are you allergic to any drugs (e.g. Penicillin)? ☐ Yes ☐ No

   If yes, please give details .....

5. Have you had any of the following:

	Yes	No		Yes	No		Yes	No
Rheumatic Fever	☐	☐	High Blood Pressure	☐	☐	Headaches	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	Hepatitis (Jaundice)	☐	☐
Bronchitis	☐	☐	Epilepsy	☐	☐	Are you HIV+?	☐	☐
Heart Trouble	☐	☐	Breathlessness	☐	☐			
Liver/Kidney Disease	☐	☐	Fainting Attacks	☐	☐			

6. Did you as a child or since have brain surgery, growth hormone treatment before the mid 1980s or have a close relative with Creutzfeldt Jakob Disease (CJD)? ☐ Yes ☐ No

   If yes, please give details .....

7. Have you ever had a bad reaction to local or general anaesthetic? ☐ Yes ☐ No
8. Have you had any other serious illness? .....
9. Have you experienced abnormal bleeding after extractions? ☐ Yes ☐ No
10. Do you smoke now (or in the past)? ☐ Yes ☐ No ☐ In the past

    If yes, how many times a day? .....

11. Do you chew tobacco, pan, use gutkha or supari now (or in the past)? ☐ Yes ☐ No ☐ In the past

    If yes, how many times a day? .....

12. If female: Are you pregnant? ☐ Yes ☐ No If yes, when are you due? .....
13. Do you carry a medical warning card? ☐ Yes ☐ No

Please give your GP's details: Name .....

Surgery address ..... Tel no .....

PATIENT SIGNATURE ..... DATE .....

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