Medical History Form

To help us give you the best and safest care possible, your dentist will need to know your most up-to-date medical history at *every* appointment. Please ensure you provide accurate and up-to-date information, especially any medication you are currently taking.

Personal Details

First Name(s)	
Surname	
Title	
Gender	
Date of birth	
NHS Number (ask your GP)	
Address	
Postcode	
Home telephone number	
Mobile telephone number	
Email address	
How did you hear about us?	

Data Protection

The Data Protection Act 1998 prevents any person or organisation from accessing or sharing personal information on an individual without their express permission. Should you wish for another individual living at your current address to be able to make/amend/discuss your dental appointments/information on your behalf, please confirm their details below:

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Please tick if you give permission for us to contact you regarding product and service information or promotion:	**YES**	**NO**
Please tick if you would like us to stop communications other than important notifications:	**YES**	**NO**

GP's Name and Address: (please state where even if you do not know the name of your doctor)

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Medication – including dose, frequency and reason required – please use another sheet of paper if required

Please complete your details in full to prevent the return of these forms and delays to your appointments.

Please indicate if you have or if you have ever had any of the following		If yes, please give details
Rheumatic fever High blood pressure Heart surgery Pacemaker fitted Heart murmur Angina Thrombosis Other heart condition	Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No	
Bronchitis Emphysema Pneumonia Chest surgery Smoker – Please state how many per day Cystic fibrosis Pleurisy	Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No	
Bleeding Hepatitis H.I.V. Anaemia Blood Test Sickle cell Haemophilia	Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No	
Serious childhood illness Diabetes Liver disease Kidney disease Epilepsy Cancer General anaesthetic experience Hiatus hernia	Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No	
Please state ALL allergies/warnings including but not limited to food / materials / medicines:		
Penicillin Hay-fever Anti-tetanus serum Eczema Aspirin Asthmatic Latex allergy	Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No	
I have problems with local anaesthetic I require regular anti-biotic cover as per my GP I have problems reclining in the dental chair I am pregnant/breast feeding I carry a warning card I have an artificial joint I drink alcohol – please state amount per week Please state your weight	Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Stone/lbs	
OTHER – please state:		

I understand a minimum of 24 hours' notice must be given to change or cancel an NHS appointment or may affect my place at Parkway Dentalcare. If I have two or more *late cancellations* or *missed appointments* Parkway Dentalcare may no longer be able to see me and that fees apply to missed private appointments.

Patient/Parent signature:

Print name:

Date:

Dentist signature:

Print name:

Date: