APOLLINE HOUSE DENTAL PRACTICE
CONFIDENTIAL MEDICAL HISTORY FORM

Apolline House
Dental Practice

TITLE…….FIRST NAME…… SURNAME……

MALE/FEMALE…….DATE OF BIRTH ……..OCCUPATION……..

ADDRESS……

PHONE NUMBER HOME……WORK……..

ARE YOU, OR COULD YOU BE PREGNANT? ……

YOUR DOCTORS NAME & ADDRESS……

HOW LONG IS IT SINCE YOU LAST VISITED A DENTIST? ……

PLEASE COMPLETE THIS NEXT SECTION AS WELL AS YOU CAN IN ORDER THAT YOUR DENTIST CAN PROVIDE YOU WITH SAFE DENTAL CARE

	Y	N	DETAILS
ARE YOU?			
Attending or receiving treatment from a doctor/hospital/clinic/specialist?			
Taking any medicines from your doctor? (tablets/creams/ointments/other)?			
Taking or have taken steroids in the last 2 years?			
Allergic to any medicines/food/materials?			
HAVE YOU?			
Had rheumatic fever or Chorea (St. Vitus Dance)?			
Had jaundice, liver, kidney disease, or hepatitis?			
Ever been told you have a heart murmur or heart problem, angina, blood pressure, heart attack?			
Had any blood tests or inoculations etc.?			
Ever had your blood refused by the Blood Transfusion Service?			
Had a bad reaction to a local or general anaesthetic?			
Had a joint replacement?			
Been hospitalised? If "YES" what for and when?			
DO YOU?			
Have arthritis?			
Suffer from Hay Fever, Eczema or any other allergy?			
Suffer from bronchitis, asthma or any other chest condition?			
Have fainting attacks, giddiness, blackouts or epilepsy?			
Have diabetes or does anyone in your family?			
Bruise easily or following a tooth extraction, surgery or injury have you or your family bled so as to cause you to be worried?			
Carry a warning card?			
Ever get cold sores?			
IS THERE ANYTHING ELSE YOU WOULD LIKE TO LET THE DENTIST KNOW?			
COMPLETED BY: PATIENT/PARENT/GUARDIAN (please circle) **SIGNED ……..** **DATE:**			