THE GALLERY DENTAL AND IMPLANT CENTRE
Something to smile about

CONFIDENTIAL MEDICAL HISTORY FORM

Title **First Names**	**Surname**	
Date of Birth: (DD.MM.YYYY)	**Male / Female**	
Address	**Postcode**	
Telephone No **Home:** **Mobile:**	**Telephone No** **Occupation:** **Work:**	
E-mail address:		
Next of kin: **Name:**	**Contact details:**	
Expectant mother YES / NO	**If yes, expected delivery date:**	
Name and address of GP		
Where did you hear about our practice?		
Is there any religious or dietary information that you need to share with us?		

IF COMPLETING FOR A CHILD:

	YES	NO	Please give details:
Do you have parental responsibility			
Who else has responsibility for this child			
Name of school			
Is this child known to social services ***If yes , who is their social worker**			

ARE YOU:

	YES	NO	Please give details:
Attending or receiving treatment from any Medical practitioner, hospital or specialist?			
Taking any medicines at all? (including tablets, liquids, creams, injections or other)			
Taking steroids, now or in the past 3 years?			
Allergic to anything? (Medicines, chlorohexadine, food, latex, products etc.)			

Please sign on the next page

HAVE YOU:

	YES	NO	Please give details:
Had rheumatic fever or chorea (St Vitus dance)?			
Had jaundice liver disease or kidney disease?			
Ever been told that you have a heart murmur or heart problem, angina, high blood pressure or heart attack?			
Had any blood tests or inoculations? (give result)			
Ever had blood refused by the transfusion service?			
Had a bad reaction to a local or general anaesthetic?			
Had a joint replacement?			
Been Hospitalised? If "yes"- what for?			

DO YOU:

	YES	NO	Please give details:
Do you smoke tobacco products now(or did you in the past) and how many			
How may units of Alcohol per week? (1 unit is half a pint of lager, 1 measure spirits, 1 glass of wine)			
Have arthritis?			
Have a pacemaker or had heart surgery?			
Suffer from hay fever, allergy, asthma or chest disease?			
Have fainting attacks, giddiness, blackouts or epilepsy?			
Have diabetes, or is there a family history?			
Bruise easily, or bleed excessively from cuts or extractions?			
Carry a warning or medicine dosage card?			
Ever get cold sores?			
Is there anything else your clinician should know about?			

We may, if necessary, need to take photographs, or forward medical data, such as impressions, bite registration and treatment plans for referral. By signing this form you will release us from obligation to treat medical records with confidentiality for the purpose of treatment.

Completed by: SELF / PARENT / GUARDIAN

Name.....

Date .....

Signed.....