Completed by (tick please) ☐ **self** ☐ **patient** ☐ **guardian**

Signature _____ Date _____

Medical History Update
Please check the health information on this form is still correct (including information on the smoking and drinking). If not, amend as necessary or note any changes below.

Date	Change? Yes/No	List any changes below	Signature

DHIMAN DENTAL
ESTABLISHED SINCE 1985
Tel: 020 8894 3141
www.dhimandental.co.uk

Dhiman Dental Surgery
169 Percy Road
Whitton, Twickenham
Middlesex
TW2 6JS

CONFIDENTIAL MEDICAL HISTORY FORM

To obtain the best and safest treatment, your dentist needs to know of any problems that may affect your treatment

Surname _____

First Name/s _____ Title _____

Sex ☐ Male ☐ Female

Date of Birth ☐ Day ☐ Month ☐ Year

Address _____

_____

_____

NHS Number _____ Postcode _____

E-Mail _____

Telephone (home) _____ Work/mobile _____

Occupation _____

Doctor's name and address _____

_____

_____

Doctor's telephone _____

How did you hear about us? _____

ARE YOU CURRENTLY	YES	NO	GIVE DETAILS
Pregnant?	☐	☐	
Receiving treatment from a doctor, hospital or clinic?	☐	☐	
Taking any prescribed medicine? (e.g. Tablets, ointments, injections or inhalers, contraceptives or hormone replacement therapy?	☐	☐	
Carrying a medicine warning card?	☐	☐	

DO YOU SUFFER FROM			
Allergies to any medicine? (e.g. penicillin), sunstances (e.g. latex/rubber) or any food?	☐	☐	
Hay fever or eczema?	☐	☐	
Bronchitus, asthma or other chest infections?	☐	☐	
Fainting attacks, giddiness, blackouts or epilepsy?	☐	☐	
Heart problems, angina, blood pressure problems or stroke?	☐	☐	
Diabetes (or does any one in your family)?	☐	☐	
Arthritis?	☐	☐	
Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐	☐	
Any infectious disease (including HIV and hepatitis)?	☐	☐	

DID YOU AS A CHILD OR SINCE HAVE			
Rheumatic fever or cholera?	☐	☐	
Liver disease (e.g. jaundice, hepatitis) or kidney disease?	☐	☐	
Any other serious illness?	☐	☐	

DID YOU, AS A CHILD OR SINCE, HAVE	YES	NO	GIVE DETAILS
Blood refused by the Blood Transfusion service?	☐	☐	
A bad reaction to general or local anaesthetic?	☐	☐	
A joint or hip replacement?	☐	☐	
Treatment that required you to be in hospital?	☐	☐	
Heart surgery?	☐	☐	
Brain surgery?	☐	☐	
Growth hormone treatment before1960?	☐	☐	
A close relative (parent, sibling, child, grandparent or grand child) with Creutzfeldt Jakob Disease?	☐	☐	

DRINKING

How many units of alcohol do you drink per week? (A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitif)	☐	☐	☐ Units per week

Smoking and chewing

Do you smoke any tobacco products now (or did you in the past)**?**	☐	☐	☐ Times per day
Do you chew tobacco, pan, use gukha or supari now (or in the past)?	☐	☐	☐ Times per day

Please give any other details which your dentist might need to know about such as self prescribed medicines (e.g. aspirin)?