

# MATFORD DENTAL CLINIC

## CONFIDENTIAL MEDICAL HISTORY

### PATIENT DETAILS

Gender		Email Address		Doctor's Name	
Title		Home Telephone		Medical Surgery Address	
First Name		Mobile Telephone		Telephone	
Surname		Work Telephone		Emergency Contact	
D.O.B.		Occupation		Name	
Address		Ethnicity		Relationship	
Postcode				Telephone number	

### MEDICAL HISTORY (PLEASE PROVIDE / ATTACH DETAILS OF ANY MEDICAL CONDITIONS AND MEDICATION)

<b>Heart</b>	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Pacemaker Fitted	<input type="checkbox"/> Heart mummer	<input type="checkbox"/> Angina	<input type="checkbox"/> Thromb	
Other Heart Conditions / Further Details								
<b>Chest</b>	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Chest Surgery	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Asthma		
Other Chest Conditions / Further Details								
<b>Blood</b>	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> H.I.V.	<input type="checkbox"/> Anaemia	<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Haemophilia		
Other Blood Conditions / Further Details								
<b>Other</b>	<input type="checkbox"/> Serious Childhood Illness	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Cancer	<input type="checkbox"/> General Anaesthetic Experience	<input type="checkbox"/> Hiatus Hernia
<b>Allergies</b>	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Hay- Fever	<input type="checkbox"/> Anti-Tetnus Serum	<input type="checkbox"/> Eczema	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Asthmatic	<input type="checkbox"/> Latex	
Other Conditions or Allergies								

### MEDICATION LIST


Do you smoke?	<input type="checkbox"/> Y <input type="checkbox"/> N	How many per day? How long have you been smoking?	
Do you drink alcohol?	<input type="checkbox"/> Y <input type="checkbox"/> N	How many units per week?	
Are you Pregnant?	<input type="checkbox"/> Y <input type="checkbox"/> N	What is your due date?	

Signature	
Today's Date	

