John G. Plummer & Associates
DENTAL SURGEONS

## CONFIDENTIAL- MEDICAL HISTORY -Please hand this form to the Dentist in surgery.

To be completed by Patient, Parent, or Guardian. Your confidentiality is protected by the Data Protection Act.
No medical problem or infection will exclude you from receiving essential treatment.
Please note that there is no guarantee that a particular operator will carry out your treatment.

Name ..... Born ... / ... / ..... Occupation .....

Address: .....

.....

Tel: ..... Mobile: .....

Medical Doctor ..... Practice Name .....

**Are you: Circle** the appropriate answer eg. (**Y**) **N** **(**please provide any **DETAILS** if the answer is **YES)**

| | | |
|---|---|---|
| **Y** | **N** | Receiving treatment from a doctor, hospital, clinic or specialist? **For what reason?** |
| **Y** | **N** | Taking any medicines, tablets, creams, ointments or injections? |

Please List here.

| | | |
|---|---|---|
| 1. | 4. | 7. |
| 2. | 5. | 8. |
| 3. | 6. | 9. |

| | | |
|---|---|---|
| **Y** | **N** | Being treated or have taken steroids in the past two years? |
| **Y** | **N** | Allergic to medication / injections (e.g. Penicillin, anaesthetic)? |
| **Y** | **N** | Allergic to any other things (e.g. nuts, latex, metal, plasters) |

| **Have you had:** | | |
|---|---|---|
| **Y** | **N** | Infective Endocarditis, Heart Valve Replacement or Shunt / Conduit? |
| **Y** | **N** | Jaundice or Hepatitis? |
| **Y** | **N** | Heart complaint (e.g. Angina, Attack, Stroke, Murmur)? |
| **Y** | **N** | Diabetes? |
| **Y** | **N** | High Blood Pressure? |
| **Y** | **N** | Bronchitis, Asthma or any other chest condition? |
| **Y** | **N** | Fainting attacks, blackouts or Epilepsy? |
| **Y** | **N** | Bleeding excessively from cuts or if you have a tooth extracted? |
| **Y** | **N** | Is there any chance that you have become infected with HIV? |
| **Y** | **N** | Frequent headaches and associated jaw pain? |

***If appropriate:*** Could you be **PREGNANT**? ……If Yes, Baby Due Date: / /

| | | | | |
|---|---|---|---|---|
| Do you carry a Medical Warning Card? | **Y** | **N** | For what reason? | |

How much do you smoke per day? ……. or per week? ……... | How much alcohol do you drink per day? ….. or / week? …….

FURTHER DETAILS (please add anything of medical importance - use overleaf if required)

If you are taking anti-clotting medication what is your **INR** ……..

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Patient Signature** | | | | | | | | | |
| **Checked By Dr.** | | | | | | | | | |
| | DATE | DATE | DATE | DATE | DATE | DATE | DATE | DATE | DATE |