Confidential Medical History Form

Name:……

Date of birth:……

Tel:……

Email:……..

Doctors name:……..

Doctors address:……

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In case of emergency contact name and tel: ……

HAVE YOU SUFFERED?	Yes	No	Relevant Details
Any Heart Complaint			
Diabetes			
Epilepsy			
Chronic Bronchitis or Asthma			
Hepatitis			
Excessive Bleeding			
High blood pressure			
Any other serious illness			
Are you allergic to any medicines or materials			
ARE YOU?			
At present taking any medicines or tablets? If so, please state.			
A smoker (how many daily)			
A drinker (how many units weekly)			
Pregnant			
The Mother of a child under 12 months old			
HIV positive			
HAVE YOU?			
Had a joint replacement operation			
Undergone any operations in the last two years			
Taken steroids in the last two years			
During treatment, some of our materials may contain animal products. Are you happy for these to be used?			

I consent for my details to be used and stored for the purposes outlined in the Brucegate Dental Practice GDPR and hereby consent to any discussions, examinations and treatment or referrals onto further organisations by dental professionals at Brucegate Dental Practice.

If you have answered **YES** to any of the questions above, please supply the details in the boxes

Signed by Self / Parent / Guardian (delete as applicable): ……

Date…… Signature…… Date…… Signature ……

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