Thurloe Street Dental.

Confidential Medical History Form

Title: Mr/ Mrs / Miss / Ms / Dr / Lord / Lady / Sir / Professor/Rev. or Other: ______________________________

Surname: ____________________________________ **First Name:** _____________________________________

Date of Birth: ________________________ **Address:** ____

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Tel (home): ______________________________ **Tel (mobile):** ____________________________________

Email: ____ **How did you hear about us:** __________________

Occupation: ______________________________ **Preferred method of contact? SMS/Mobile/Email/Landline**

Dental Insurance Provider and Policy Number, if any: ____

Score 1- 10: (10 being amazing, 1 being horrible) How happy are you with your smile? _________________
Score 1- 10: (10 being extremely anxious, 1 being not anxious at all) How anxious are you to be here? _____
Next of Kin Name: ___________________________________ **Telephone No:** ____________________________

Please fill in this section carefully. It is important that your dentist has your full medical history. Please ask your dentist's advice if you are unsure about any of the questions.

GP Name/Address/Tel No: ____

Do you have or have you ever suffered from:

Rheumatic Fever	Yes/No
Any heart complaint/heart surgery or stroke	Yes/No
Diabetes	Yes/No
Epilepsy	Yes/No
Fainting attacks	Yes/No
Chronic Bronchitis or Asthma	Yes/No
Hepatitis	Yes/No
HIV/AIDS	Yes/No
High Blood Pressure	Yes/No

Did you as a child or since have brain surgery, growth hormone treatment before the mid-1980's or have a close relative with CJD?	Yes/No
Have you any allergies to medicines ie penicillin, substances or materials (latex/rubber)?	Yes/No
Have you had any ill effects from local anaesthetic?	Yes/ No
In the past 2 years have you undergone any surgery: ____	
Are you pregnant or is there a chance you might be pregnant	Yes/No
In the past 2 years have you been treated with hydrocortisone or steroids	Yes/No
Have you ever had a joint or hip replacement operation	Yes/No
If you smoke, what is your average per week? ____________	

Please list your prescription medication: ____
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Your Signature ____ **Date** __________________________