Medical History Confidential

Failure to disclose all details may result in us being unable to treat you as it may put your health at risk or compromise your dental treatment.

Data Protection: Please see over for details.

arnica dental care

Name _____ D.O.B _____

Address _____

Email _____ Mobile _____ Occupation _____

Name & Address of GP: _____

Next of Kin/Person to Contact in an Emergency Name: _____

Work/Home Telephone/s: _____ Mobile: _____

DO YOU or HAVE YOU EVER HAD?	YES	NO	PLEASE GIVE DETAILS
Hospitalization for illness or injury			
Allergies to medicines (antibiotics, sleeping tablets)			
Allergies to latex/foods/other			
Heart problems, angina, palpitations or stroke			
High or low blood pressure			
Anaemia or other blood disorder			
Excessive bleeding requiring treatment			
Rheumatic Fever			
Tuberculosis (TB)			
Asthma, bronchitis or chest conditions			
Liver or kidney disease, jaundice or hepatitis			
Thyroid or hormone deficiency			
High cholesterol or taking statin drugs			
Diabetes (or anyone in your family)			
Stomach or duodenal ulcer			
Digestive disorders (i.e. gastric reflux)			
Osteoporosis/osteopenia (bisphosphonates)			
Arthritis			
Head or neck injuries			
Epilepsy convulsions (seizures)			
Cold sores			
Lumps or swellings of the mouth			
Hayfever, hives, skin rash or eczema			
Infectious diseases (including HIV/AIDS)			
Tumour abnormal growth			
Chemotherapy/Radiation therapy			
Antidepressant medication			
Do you carry a medical warning card			
Do you drink alcohol			How many units per week?
Do you chew tobacco products			
Do you smoke or have you ever smoked			How many per day?
Do you take recreational drugs			
Have you ever had a general anaesthetic			Any problems?
Have you ever had sedation (tablet, gas and air, injection in hand/arm, other)			What type? When?
Any family history of problems with anaesthetic or sedation			
Any history of sleep apnoea			
FEMALE: Are you pregnant or might be			
FEMALE: Taking birth control pills			

Please list all medication, impending surgery, or any other treatment you are currently receiving (continue over if required):

Patient Signature: Date: Dentist Signature: Date:

Medication:

Impending Surgery:

Other treatment:

Data Protection: We take your Data Privacy very seriously. The information you provide here is classed as ‘sensitive’ and will be scanned onto your records within our secure patient management system. After scanning this form will be shredded.

For information about how we protect your data please request a copy of our Privacy Notice from reception or go to **www.arnicadentalcare.co.uk/privacy-notice.**

For more information about our Data Protection Policy and Procedures please do not hesitate to speak to a member of the team.