CONFIDENTIAL MEDICAL HISTORY

Penny Wiles Dental Practice

To provide the best and safest treatment for you, we need to know of any problems which may affect your dental care. All the questions below are relevant to dental health and care and I would be grateful if you could answer them as fully as possible. All information recorded is confidential.

TITLE: Dr/Mr/Mrs/Miss/Ms	First Name(s):	Surname:
Date of Birth:	Occupation:	email address:
Address:		Post Code:
Tel: Home:	Mobile:	Work:
Doctor's Name and address:		

1. Are you currently having treatment or investigations from a doctor or hospital? YES/NO
   If **yes** please provide details; ……
   ……
   ……
2. Please list **all** medications you currently are taking including inhalers, creams, drops and injections;
   ……..
   ……..
   ……..
3. Are you allergic or sensitive to any medications, substances or food? YES/NO
   If **yes** please provide details; ……..
   ……..
4. Ladies, are you or do you think you may be pregnant? YES/NO
5. Have you **ever** been in hospital? YES/NO
   If **yes** please provide details; ……..
   ……..
6. If you damage yourself do you bruise or bleed easily? YES/NO
7. If there are any other aspects of your general health that you feel may be relevant to your dental care please provide details; ……
   ……..

Do you smoke? YES/NO	If **yes**, how many cigarettes/ounces per day:
Do you drink alcohol? YES/NO	If **yes**, how many units per week:

Completed by self/parent/guardian: Signature: …….. Date: ……
Clinician Signature: …….. Date: ……

If the information on this form is still correct please complete below: (If not we kindly request that you complete a new form)

Patient sign+date: …… Patient sign+date: …… Patient sign+date: ……

Clinician sign+date: …… Clinician sign+date: …… Clinician sign+date: ……

ASA……..

Penny Wiles Dental Practice
53 St Augustines Street, Norwich, Norfolk, NR3 3BG
Tel: 01603 624012 email: reception@pennywiles.co.uk