M. M. A. Laljee & Associates

Chineham Dental Surgery

CONFIDENTIAL MEDICAL HISTORY

To provide the best and safest treatment, your dentist needs to know of anything that may affect your treatment.

IMPORTANT: PLEASE COMPLETE ALL SECTIONS

First Name (s):		**Surname:**				
Date of Birth:		**Title:**		**Sex:**	Female	Male
First line of Address:						
Postcode:		**Home Tel:**				
Mobile Number:		**SMS Reminder:**	Yes	No		
Email Address:		**Email Reminder:**	Yes	No		
Work Number:		**Occupation:**				
GP Name & Surgery Address:		**NHS number:**				

	Yes	No		Yes	No
Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?			**Have you ever had a bad reaction to a local or general anaesthetic?**		
Are you taking any medicines, tablets, drugs or injections or using any creams, ointments or inhalers?			**Have you ever been told you have a heart murmur, heart problem, angina or high blood pressure?**		
Are you or have you ever been treated for Osteoporosis?			**Have you been hospitalised for any reason?**		
Are you taking or have you taken steroids?			**Do you have Arthritis?**		
Do you have any known allergies including penicillin or latex? Do you suffer from hay fever or eczema?			**Do you have a Pacemaker or have you had heart surgery?**		
Are you pregnant or a nursing mother?			**Do you have asthma or any other chest condition?**		
Do you have any infections or diseases (including HIV and Hepatitis)?			**Do you have fainting attacks, dizziness, blackouts or epilepsy?**		
Have you had Rheumatic Fever or Chorea?			**Do you have diabetes or does anyone in your family?**		
Have you now or in the past has Jaundice, liver or Kidney disease or Hepatitis?			**Do you carry a warning card?**		
Did you as a child or since or have a close relative with CJD?			**Do you bruise or bleed easily or excessively?**		
Have you had a joint replacement or other implant?			**Have you ever had brain surgery?**		
Have you ever been refused by the Blood Transfusion Service?			**Do you think there are any other aspects, concerning your health that your dentist should know about?**		

IF THE ANSWER IS YES TO ANY OF THE ABOVE QUESTIONS, PLEASE PROVIDE DETAILS IN THIS BOX:
(the reverse of this form can be used if additional space is required)

On average, how many units of alcohol do you drink per week?					
Do you smoke? If so how many per day?			**Do you chew tobacco?**	**Yes**	**No**
Are you happy with the overall appearance of your mouth?	**Yes**	**No**	**Would you like to budget your dental care?**	**Yes**	**No**
Do you experience any problems when chewing?	**Yes**	**No**	**Last Dental Visit:** (approx)		

SIGNED:_____**DATE:**_____

Patient / Parent / Guardian (delete as applicable)