Medical History

Form 3

Please write clearly

For office use

CHI Number D D M M Y Y

Surname

Forename

Please tick appropriate box. If you have further details, including any allergies or pills, tablets or other medication that you take, **please enter them in the 'Further Details' box.**

	Yes	No	Unsure
Are you aware of anything that you are allergic to? (penicillin or another antibiotic, pollen, latex, food, jewellery or any other substance)	☐	☐	☐
Have you ever had any heart problems/conditions? (blood pressure problems, angina or chest pains, pacemaker or any other heart or blood vessel condition)	☐	☐	☐
Have you ever had any chest or breathing problems/conditions? (asthma, bronchitis or any other breathing problems)	☐	☐	☐
Have you ever had any stomach, gut, liver or kidney problems/conditions?	☐	☐	☐
Do you have any blood or bleeding problems/conditions?	☐	☐	☐
Are you prone to fits/faints or do you have epilepsy?	☐	☐	☐
Do you have any problems or conditions relating to your bones, joints or muscles? (arthritis, muscle weakness or any other condition)	☐	☐	☐
Do you have hepatitis, HIV, AIDS or tuberculosis (TB)?	☐	☐	☐
Are you pregnant or is there a possibility you could be pregnant?	☐	☐	☐
Do you have diabetes?	☐	☐	☐
Do you have a medical condition or problem not specified above?	☐	☐	☐
Are you currently under treatment from a doctor, consultant or clinic?	☐	☐	☐
Do you carry a medical warning card?	☐	☐	☐
Are you taking or meant to take medicine prescribed by your doctor or otherwise? (tablets, pills, patches, medicines, inhalers, ointments, injections, oral contraceptives, herbal remedies, recreational drugs, recent vaccinations). If yes, please enter them in the 'Further Details' box overleaf.	☐	☐	☐
Are there any conditions that run in your family? (diabetes, sickle cell disease or any other conditions). If yes, please enter them in the 'Further Details' box overleaf.	☐	☐	☐
Have you ever had an illness or operation that required hospital treatment? If yes, please enter them in the 'Further Details' box overleaf.	☐	☐	☐

PTO

Medical History — Form 3 (cont.)

Additional Requirements or Special Needs (Please tick appropriate box or boxes)

- ☐ Visual impairment
- ☐ Hearing difficulties
- ☐ Learning difficulties
- ☐ Communication difficulties
- ☐ Mental health difficulties
- ☐ Physical disability
- ☐ Wheelchair user
- ☐ Hoist transfer required
- ☐ None
- ☐ Other (Please give details if appropriate)

If you are an armed forces veteran, please tick here ☐

Further Details including any allergies or pills, tablets or other medication that you take

After you have completed this form please return it to a member of the Dental Team.

Signature of Patient, Parent or Carer _____

Date _____