Confidential Medical History Form

ENDO MISHRA
The root canal specialist

We ask you for information abour your general health to help us treat you safely. Please write your contact details below, answer the health questions and then sign the form on the back page. We will use this form at later visits to discuss any change in your general heatlh. All information will be kept strictly confidential.

Title		Last name		First name	
Sex		Preferred Name		DOB	
Address				Post Code	
Home Phone			Mobile		
Occupation			Email		

Previous occupation if retired

In the event of an emergency, please contact

Name		Phone		Relationship to you	

Doctor's details

Doctor's Name		Post Code	
Address			

Are you currently:	**Yes**	**No**	**Please give details.**
Receiving treament from a doctor, hospital or clinic?	☐	☐	
Taking any prescribed medicines *e.g. warfarin, bisphosphonates, or other tablets, ointments, injections or inhalers, including contraceptives and hormane replacement therapy?	☐	☐	
Carrying a medical warning card?	☐	☐	
Pregnant or possibly pregnant?	☐	☐	

Have you ever had:	**Yes**	**No**	**Please give details.**
Allergies to medicines (e.g. penicillin), sub-stances (e.g. latex/rubber) or foods?	☐	☐	
Bronchitis, asthma or other chest conditions?	☐	☐	
Fainting attacks, giddiness, blackouts, epilepsy?	☐	☐	
Heart problems, angina, blood pressure problems or stroke?	☐	☐	
Diabetes (or does anyone in your family)?	☐	☐	
Bone or joint disease?	☐	☐	
Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐	☐	

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Continued

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Have you ever had:	**Yes**	**No**	**Please give details.**
Liver disease (e.g. jaundice, hepatitis) or kidney disease?	☐	☐	
Any other serious illness or infectious disease?	☐	☐	
Blood refused by the Blood Transfusion Service or any other agency abroad?	☐	☐	
A bad reaction to general or local anaesthetic?	☐	☐	
Treatment that required you to be in hospital?	☐	☐	
Heart surgery or a stent?	☐	☐	
Any form of mental illness (e.g. depression, anxiety, stress, eating distorders)?	☐	☐	

Alcohol	**Please give details.**
How would you describe your consumption of alcohol? Non-drinker, modest, moderate, more than is probably good for me, heavy?	

Smoking	**Yes**	**No**	**In the past**	**How many times per day?**
Do you smoke any tobacco products now (or did you in the past?	☐	☐	☐	
Do you chew tobacco, pan, use gutkha, supari, or betel now (or did you in the past)?	☐	☐	☐	
Would you like help or advice reducing or quitting alcohol or tobacco products?	☐	☐		

Please give any other details which your dentist might need to know about such as self-prescribed medicines (e.g. Aspirin) or any disabilities or health concerns you may have.	
Please rate your dental nervousness or anxiety 0-10 (0 not nervous at all, 10 too anxious to consider treatment)	

Disclaimer

Completed by: Self ☐ Parent ☐ Guardian ☐ Other - Please state

Patient Signature		Dentist Signature	
Date		Date	