Robin Smith confidential medical history form & confidentiality consent questions

Please complete and sign this form to help me and my team to treat you better. All information will be kept strictly confidential, **and you can alter details and remove or alter any aspect of your consent in future, just tell us**

Name			Date of birth
Address			GP's name GP's address GP's tel
Daytime contact tel numbers (*only fill in if you are happy to be contacted on them)*			Your email
Home Can we leave a message on this number?			Occupation
Work Can we leave a message on this number?			*In an emergency please contact* - Name *on* Tel
Mobile Can we leave a message on this number?			
Can we contact you by letter?	Can we SMS (text) you?		Can we email you?
Is there anyone you trust us to talk to on your behalf? If happy, tick and add name below			
Can we leave messages with them?			NAME
Can they make or change your appointments?			
Can we tell them about any aspects of your/your child's dental treatment?			
QUESTIONS	YES	NO	DETAILS
Do you suffer from **memory loss** eg from dementia or following a stroke?			
Are you **receiving treatment or have you recently undergone tests** from a doctor, hospital or clinic?			
Are you taking any **medicines**, prescribed or otherwise *(eg tablets, ointments, injections or inhalers; including, contraceptives, HRT or aspirin)*?			
Are you taking or have you taken **steroids** in the last 2 years?			
Do you carry a **medical warning card**?			
Have you ever been **allergic** to any medicines (*eg penicillin*), substances (*eg latex or rubber*) or foods?			
Do you have **heart problems**, **angina**, **blood pressure problems** or a history of **strokes**?			
Do you have **diabetes** (or does anyone in your **family**)?			
Do you have **bronchitis**, **asthma** or other **ches**t condition?			
Do you have **fainting** attacks, **giddiness**, **blackouts** or **epilepsy**?			

PTO

	YES	NO	DETAILS
Do you have **bone or joint disease** including arthritis and osteoporosis?			
Do you have **kidney disease or liver disease** (eg jaundice, hepatitis)?			
Do you suffer from **any other serious illness**?			
Have you **ever had heart surgery or infective endocarditis**?			
Have you ever had any other **operation or** been **admitted** to hospital with a **major problem**?			
Do you suffer from **bruising or persistent bleeding after surgery, injury or tooth extraction**?			
Have you ever had a **bad reaction** to local or general **anaesthetic**?			
Have you ever had **blood refused** by the Blood Transfusion Service?			
Are there **any other medical details your dentist might need to know**?			
Do you ever have **cold sores or impetigo**?			
Do you have **learning or social communication difficulties**?			
Do you have any **dentally related problem** we should know about **eg** phobia/needle phobia/sensitive gag reflex?			
Have you or any of your household ever had a positive covid test? Or symptoms in the last 7 days (for you) or 14 (for a member of your household?			
The next questions are designed for adults			
*Do you smoke **or** chew **tobacco** (**or** chew pan, gutcha or supari)? YES **OR** NO* ***IF YES** how many a day?*			
***Did you** smoke (**or** chew tobacco/pan/gutcha/supari) **in the past**?*			
*How many **units* of alcohol** (**** a glass of wine, ½ pint of lager or a single measure of spirits) do you drink on average in a week?*			
Might you be pregnant? YES/NO			
SIGNED** by patient/parent/guardian* ***Date			
SIGNED** by dentist when form is checked* ***Date			
***For later visits** – have **any** of your **details changed**? Please check, change, sign and date*			

Date	Any changes?	If changes– insert details	Patient/parent/guardian's signature	Dentist/hygienist's signature