Wyndcott Dental

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CONFIDENTIAL Medical History Form

Mr / Mrs / Miss / Ms /_____First Names _____ D.O.B. _____

Surname _____

- IF CHANGED -

Home Address: _____

_____ *Post code:* _____

Home Phone: _____ *Mobile Phone:* _____

Email (parent or guardian if under 16) _____

We use email and/or SMS to send appointment reminders. May we also send information about offers ? ☐ *Yes* ☐ *No*

Contact Preference: ☐ *Home Phone* ☐ *Mobile Phone* ☐ *Email* ☐ *SMS/Text* ☐ *Post*

Emergency contact name: _____ *Phone Number:* _____

*Doctor's Name: Dr.*_____ *Practice:* _____ *Town:* _____

-- EVERY 6 MONTHS --

MEDICAL HISTORY

1. Have you been a patient in hospital or been to a Doctor during the past two years? Please describe if yes.
   ☐ No ☐ Yes _____
2. Have you taken any prescription medicine (tablets, capsules) during the past two years? Please list medication or bring a list
   ☐ No ☐ Yes _____
   _____
3. Do you have any allergies? (E.g. from any medicines, anaesthetics, food, latex?)
   ☐ No ☐ Yes _____
4. Have you ***ever*** had any of the following conditions , or ***ever*** taken any of the medications in this list ? (Tick all boxes that apply).

☐ Autism / ASD
☐ ADHD
☐ Learning Disability
☐ Epilepsy / Seizures / Fits
☐ Depression
☐ Alzheimers / Dementia
☐ Bipolar / Schizophrenia
☐ Severe headaches
☐ Drug dependence
☐ Hepatitis type: ☐ A ☐ B ☐ C

☐ Heart trouble / Angina / Stroke
☐ **Postural Tachycardia (PoTS)**
Blood pressure: ☐ High ☐ Low
☐ Anaemia
☐ **Persistent bleeding or easy bruising**
☐ Aspirin as a blood thinner
☐ **Warfarin** ☐ Any other blood thinner
☐ Arthritis or Osteoporosis
☐ Bisphosphonates (eg Alendronic acid)
☐ Cold sores

☐ Asthma
☐ Bronchitis / TB / COPD
☐ Thyroid problems
☐ Kidney or urinary tract disease
☐ Liver disease
☐ Gastric problems
☐ Diabetes
☐ Other _____

☐ Do Not Resuscitate

5. Have you had any prosthetic surgery or any other serious problems? (E.g. Heart Valve or Hip Replacement, Broken back)
   ☐ No ☐ Yes _____
6. Are you pregnant? ☐ No ☐ Yes: _____ months
7. Are you HIV positive or at risk of exposure? ☐ No ☐ I am HIV positive ☐ I am at risk of exposure to HIV
8. What concerns do you have? ☐ Crooked teeth ☐ Colour ☐ Missing Teeth ☐ Snoring ☐ Metal Fillings ☐ Other
9. Do you use: ☐ Tobacco ☐ Vapes ☐ Cannabis/Marijuana ☐ Paan ☐ Quit: (year) _____ If Yes: _____ per day
10. Would you like help to quit using tobacco ? ☐ No ☐ Yes
11. Do you drink alcohol? ☐ No ☐ Yes: _____ units per week (average)
12. Do you weigh: ☐ Less than 21 stones / 133Kg ☐ 21 to 35 stones (133-222Kg) ☐ More than 35 stones (222Kg)

➔ SIGN: **Patient / Parent / Guardian** _____ **Date:** _____

Wyndcott Dental holds and uses your data in compliance with GDPR/DPA2018 for the provision of healthcare.