The Ivy Dental Practice Confidential Medical History Form

For or your safety; it is important that your dentist is aware of your current and past medical history.
The information is bound by data protection laws and is for our information only.

Title: Mr/Miss/Mrs/Ms/Mx/Master/Dr (Please Circle)

Name: _____

Date of Birth: _____ Email: _____

Telephone: _____

Address_____Postcode_____

Which of the following best describes how you think of yourself (completion for under 16 years optional)?

☐ Man (including trans men) ☐ Woman (including trans women) ☐ Non-Binary ☐ In another way (please state): _____

Is your gender the same as you were assigned at birth? ☐ Yes ☐ No

Which of the following best describes how you think of yourself? ☐ Heterosexual/Straight ☐ Lesbian/Gay ☐ Bisexual

☐ In another way (please state): _____

Medical history – please tick yes or no to the following questions.	**Yes**	**No**
Are you currently receiving treatment from a doctor, hospital or clinic?		
Do you suffer from allergies to any medicine (e.g. Penicillin, substances (e.g. latex/rubber) or foods?		
Are you carrying a medical warning card?		
Are you currently pregnant?		
Do you suffer with bone or joint disease?		
Do you suffer from bronchitis, asthma or other chest conditions?		
Do you have Diabetes?		
Do you have an Eating Disorder?		
Do you suffer from fainting attacks, giddiness, blackouts or epilepsy?		
Do you suffer from Gastro – Oesophageal or Acid Reflux?		
Do you suffer from heart problems, angina, blood pressure problems or had a stroke?		
Do you suffer from any infectious diseases (including HIV or Hepatitis)?		
Have you ever had liver disease (e.g. jaundice, hepatitis) or kidney disease?		
Any other condition not listed here?		
Are you currently taking any prescribed medicines (e.g. tablets, ointments or inhalers, including contraceptives and hormone replacement therapy)?		
Do you smoke? If so how many per day?	Per day	
Do you drink alcohol? How many units per week? One unit is measured at 10ml or 8g of alcohol.	Units	

<u>Please give the name of your GP and/or Clinic below:</u>
Practice name:
Address:

Social worker (if applicable):

<u>Please list any current prescribed medication:</u>

ANY OTHER INFORMATION		
Signed		**(If signing for someone else, relationship to patient)**
Date		❑ Parent/guardian ❑ Partner ❑ Other _____

Checked By **Dentist**:

(Reception please double check the e mail, mobile number and medical practice)

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