# Fylde Dental Clinic

Private Dental Health Services

Confidential Medical History Form Your medical history is very important. Please fill out this form as accurately as possible so we can provide the best dental care for you. Thank you.

First Name: ______________________ Date of Birth: ______________________

Surname: ______________________ Male / Female Please circle

Home Address: ______________________ Preferred contact telephone number:

______________________ ______________________

______________________ Alternative contact number (if applicable):

Post Code: ______________________ ______________________

GP Surgery: Please tick below, or detail if not listed ______________________

- ☐ Poplar House Surgery
- ☐ Parcliffe Medical Centre
- ☐ Clifton Medical Practice
- ☐ Ansdell Medical Centre
- ☐ Holland House Surgery
- ☐ Fernbank Surgery
- ☐ Abbey Dale Medical Centre
- ☐ Stonyhill Medical Practice

Emergency Contact Name: ______________________ Relationship to you: ______________________

Their phone number: ______________________

**Please list any regular medication / inhalers / injections / infusions that you take below…**

______________________

______________________

______________________

______________________

______________________

______________________

______________________

______________________

**Are you allergic to anything?**

☐ No ☐ Penicillin ☐ Latex ☐ Other please detail ______________________

______________________

Please turn over ⮌

**Do you have or have you ever had…?**

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ angina
- ☐ heart failure
- ☐ a stroke/TIA When did this take place?________________
- ☐ a heart attack When did this take place?_______________
- ☐ heart surgery What type of surgery and when?___________
- ☐ a pacemaker fitted When did this take place?___________

☐ asthma ☐ COPD ☐ TB ☐ bronchitis ☐ emphysema

- ☐ arthritis
- ☐ osteoporosis
- ☐ diabetes
- ☐ thyroid problems
- ☐ epilepsy
- ☐ parkinson's disease
- ☐ dementia
- ☐ IBS / Crohn's / Colitis
- ☐ kidney disease
- ☐ liver disease
- ☐ hepatitis
- ☐ HIV

☐ any bleeding or blood disorders if so please detail ____________________________________________

☐ cancer if so please detail ____________________________________________

☐ chemotherapy or radiotherapy if so please detail ____________________________________________

☐ any mental health conditions eg anxiety / depression / bipolar disorder / schizophrenia / eating disorders
if so please detail ____________________________________________

☐ hearing issues ☐ a visual impairment ☐ a learning disability

**Are you pregnant or breastfeeding?** ☐ No ☐ Yes Baby's due date / Baby born ____________________

**Do you have any other health conditions?**

☐ No ☐ Yes Please detail ____________________________________________

____________________________________________

____________________________________________

**Have you ever had a cold sore?** ☐ No ☐ Yes

Please be aware that if you have an active cold sore we may not be able to carry out any treatment, please phone us in advance of your appointment to discuss your options.

**Do you smoke?**

☐ No ☐ Yes Vape Socially 5 10 15 20 40 40+ cigarettes per day Please Circle
For how many years? _________

**Have you smoked in the past?**

☐ No ☐ Yes Vape Socially 5 10 15 20 40 40+ cigarettes per day Please Circle
For how many years? _________

**Do you drink alcohol?**

- ☐ No
- ☐ Less than 14 units per week
- ☐ Rarely
- ☐ More than 14 units per week
- ☐ Occasionally
- ☐ Binge Drinking

**I consent for Fylde Dental Clinic to access my medical records via my GP surgery if needed**

☐ Yes ☐ No

**I confirm that all of the above information is correct and up to date**

Date: / / 2023 Signed by Patient: __________________ Signed by Dentist: ______________