NEW PATIENT CONFIDENTIAL MEDICAL HISTORY FORM

MARKET HOUSE
DENTAL PRACTICE - CHICHESTER

To obtain the best and safest treatment, our dentists need to know of any problems which may affect your treatment. Please advise if you need any special assistance when you are at the practice.

On completing this form:

- If you have completed this form digitally, please email the completed PDF to **reception@markethousesurgery.co.uk**
- If you have printed and completed this form by hand, please post it to us at the following address: **Market House Dental Practice, Market House, Market Avenue, Chichester, West Sussex, PO19 1JR**

YOUR DETAILS:

Title Mr Mrs Miss Ms

First name

Surname

Date of birth
DD MM YYYY

Address

Postcode

Telephone Home Work

Mobile

Email address

Occupation

Name of your doctor

Your doctor's address

Postcode

Name of next of kin

Next of kin telephone

When did you last receive treatment?

Do you have any private medical/dental cover?

How did you hear about Market House Dental Practice?

ARE YOU:

1. If female are you pregnant?

Yes ☐ No ☐ Details

2. Attending or receiving treatment from a doctor, hospital, clinic or specialist?

Yes ☐ No ☐ Details

3. Have a pacemaker, or have you had any form of heart surgery? If YES, which side is the pacemaker on?

Yes ☐ No ☐ Details

4. Taking or have taken steroids in the last two years?

Yes ☐ No ☐ Details

5. Taking or ever taken any medication for osteoporosis?

Yes ☐ No ☐ Details

6. Taking any medicines from your doctor (e.g. tablets, creams, ointments, injections)? If YES, please list here.

Yes ☐ No ☐ Details

7. Allergic to any medicines, ESPECIALLY PENICILLIN, foods or materials?

Yes ☐ No ☐ Details

HAVE YOU:

1. Had a bad reaction to a local or general anaesthetic?

Yes ☐ No ☐ Details

2. Had rheumatic fever or chorea (St Vitus Dance)?

Yes ☐ No ☐ Details

3. Ever been told you have a heart murmur or heart problems, angina, blood pressure, heart attack?

Yes ☐ No ☐ Details

4. Had jaundice liver, kidney disease or hepatitis?

Yes ☐ No ☐ Details

5. Had any blood tests, inoculations etc?

Yes ☐ No ☐ Details

6. Ever had your blood refused by the Blood Transfusion Service? If YES, were you told why?

Yes ☐ No ☐ Details

7. Any psychological disorders (e.g. depression, anxiety)?

Yes ☐ No ☐ Details

8. Any behavioural considerations (e.g. Aspergers, ADHD)?

Yes ☐ No ☐ Details

9. Been hospitalised? If YES, what for and when?

Yes ☐ No ☐ Details

10. Had a joint replacement? If YES, which?

Yes ☐ No ☐ Details

DO YOU:

1. Have arthritis?

Yes ☐ No ☐ Details

2. Suffer from hay fever, eczema or any other allergy?

Yes ☐ No ☐ Details

3. Suffer from bronchitis, asthma or chest condition?

Yes ☐ No ☐ Details

4. Have fainting attacks, giddiness blackouts or epilepsy?

Yes ☐ No ☐ Details

5. Have diabetes or does anyone in your family?

Yes ☐ No ☐ Details

6. Bruise easily or following a tooth extraction, surgery or injury, have you or your family bled so as to cause you to be worried?

Yes ☐ No ☐ Details

7. Carry a warning card?

Yes ☐ No ☐ Details

8. Ever get cold sores?

Yes ☐ No ☐ Details

9. Smoke?

Yes ☐ No ☐ Details

Are there any other aspects concerning your health that you think the dentist should know about?

☐ I understand that consultations and treatment are carried out privately. A fee is payable for consultations and I have been informed of this fee. I agree to pay all fees incurred for consultation and treatment.

☐ I consent to Market House Dental Practice contacting my doctor if they feel it is necessary.

☐ I consent to this information being held by Market House Dental Practice on paper and on computer under the terms of the 1998 Data Protection Act (please see note on reverse).

Completed by Self ☐ Parent ☐ Guardian ☐

Signature

Print name

Date DD MM YYYY

CONTACT PREFERENCES:

Our computerised appointments system enables us to contact you by text message and/or email as well as by phone or letter.

Please tick your preferred contact for appointment reminders:

Text message ☐ Email ☐

Please note patient identifiable information is only communicated outside the practice for the purpose of further treatment by specialists. If you wish us to restrict this information in any way, please advise us.