Naidu & Naidu
Dental Surgeons

Medical History Form

Certain medical conditions and medications can affect dental treatment. You will be asked to complete one of these forms every 6 months to keep your record up-to-date.

All personal details will be kept strictly confidential.

Title: ____ **Surname**: _____ **First Name(s)**: _____

Date of Birth: ___ / ___ / _____ ☐ **Male** ☐ **Female** **NHS Number**: _____

Address: _____

_____ **Postcode**: _____

Tel: Home: _____ Mobile _____ Work: _____

Email: _____ **Occupation**: _____

Ethnic Origin: _____ **Language (if not English)**: _____

Next of Kin: _____ >>> **Telephone Number**: _____

For *New Patients*: **Source of Referral**: ☐ Walk by ☐ Family/ Friend ☐ Website ☐ Internet Search

☐ Comparethetreatment.com ☐ Other _____

Do you have or have you had any of the following?
(Please Circle)

Y/N Rheumatic Fever
Y/N Heart Problems (Disease/Attack/Surgery)
Y/N Chest Pain / Angina
Y/N High/Low Blood Pressure (please delete)
Y/N Bronchitis / Asthma / Emphysema / COPD
Y/N Diabetes
Y/N Epilepsy
Y/N Kidney Problems
Y/N Liver Problems / Hepatitis
Y/N Excessive Bleeding / Blood disorders
Y/N Anxiety
Y/N Infectious Diseases e.g. HIV, Hepatitis, etc
Y/N Cancer
Y/N Joint Replacement If 'Y'_____
Y/N Ever been hospitalised for any conditions
If 'Y' _____
Y/N Any other conditions If 'Y'_____
_____

Are you:

Y/N Allergic ☐ Penicillin/Amoxicillin ☐ Latex
☐ Other _____
Y/N Receiving any treatment from a doctor, hospital or clinic? _____
_____

Do You or Are You any of the following?

Y/N Smoke If 'Y' How many per day? _____
Y/N Drink Alcohol
If 'Y' Average Units/week _____
(1 unit = ½ pint / 1 shot of spirit / Small wine)
Y/N Use Recreational Drugs?
If Y _____
Y/N Have a high acid intake?
(Fizzy or sports drinks, juices, smoothies, fruits)
Y/N Eat sugary foods
(Chocolate, biscuits, cakes, sweets, etc.)
☐ 0-1/day ☐ 2-4/day ☐ 5+/day

For Women: Are you

Y/N Pregnant or likely to be pregnant
Y/N Nursing mother
Y/N Taking Oral Contraceptives

Medications: (Please list overleaf if necessary)

_____
_____
_____
_____
_____
_____

Doctor's Name & Address: _____
_____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information provided.

Patient's Signature: _____ Date: _____ Dentist's Signature: _____