PURE
- dental health -

CONFIDENTIAL MEDICAL HISTORY FORM

Name ....

Date of Birth ....

Address ....

Telephone Home: **Work:** **Mob:** ....

Email: **Doctors & Surgery:** ....

Emergency Contact: ....

If you answer No to any of the questions in BOLD please move onto the next question	NO	YES	Details	ASA
Do you experience chest pain upon exertion? If so				2
Have you had to reduce your activities?				3
Have the complaints increased recently?				3
Do you have chest pain at rest?				4
Have you ever had a heart attack?			When was it?	2
Was the heart attack in the last 6 months?				3
Do you still have complaints?				4
Do you have a heart murmur or heart valve dysfunction, or an artificial heart valve?				2
Have you had heart or vascular surgery?			When was it?	3
Have you ever had rheumatic fever?			When was it?	3
Have you ever had endocarditis?			When was it?	4
Do you have heart palpitations without exertion?				2
Do you have to rest during palpitations?				3
Are you short of breath or dizzy at these times?				4
Have you ever had high blood pressure?				2
Do you have a tendency to bleed after injury or surgery?				3
Do you suffer from spontaneous bruising?				4
Do you suffer from epilepsy?				2
Do you continue to have seizures?			When was last seizure?	3
Do you suffer from asthma? If so			When was last attack?	2
Do you use inhalers?				2
Is your breathing difficult today?				4
Do you have hay fever or eczema?				2
Do you have other lung problems? If so				2
Are you short of breath climbing stairs?				3
Are you short of breath getting dressed?				4
Do you have any allergies to any medicines (eg antibiotics) substances (eg latex) or foods?				2

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	NO	YES	Details	ASA
Do you have diabetes? If so				2
Are you on insulin?				2
Is you diabetes poorly controlled at present?				3
Do you suffer from liver disease? If so				2
Have you had a liver transplant?				3
Do you have a kidney disease? If so				2
Are you undergoing haemodialysis?				3
Have you ever had a kidney transplant?				3
Have you ever had an operation? If so				2
Have you had GA or sedation?				2
Were there any complications?				2
Have you had a joint replacement?				2
Have you ever had a malignant disease or leukaemia? If so				2
Have you ever had chemotherapy?				3
Have you ever had a bone marrow transplant?				3
Have you ever had radiotherapy for a tumour?			What part of your body?	4
Have you suffered from/are you suffering from an infectious disease? If so give details				2
Have you ever fainted? If so when?				2
Are you pregnant or trying to conceive?				2
Do you suffer from arthritis? If so				2
Rheumatoid arthritis?				2
Osteo arthritis?				2
Have you ever suffered from a stroke?				2
Do you have any neurological disorders?				2
Multiple Sclerosis				2
Parkinson's Disease				2
Huntington's Chorea				2
Any other?				
Do you drink alcohol? If so				2
How many units per week?				
Do you smoke? If so				2
What do you smoke?				
How many per day?				
Do you take any self-prescribed drugs? If so what are they?				2
Do you have a pacemaker? When was it fitted?				
Are you/were you on any medication? If so what are/were they?				

Please Sign ______________________ Date ______________________