MOS HERTFORDSHIRE

www.moshertfordshire.com

Welcome to MOS Hertfordshire

You will shortly be going through to see your Oral Surgeon for your treatment. Before you do, please take a few moments to answer the questions on this form. It will help us to tailor our services to your requirements. Should you have any queries please be assured that your Oral Surgeon will be available to discuss these with you. Information received will be treated with strictest confidence.

CONFIDENTIAL MEDICAL HISTORY FORM

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Surname _____

Forename _____

Address _____

_____

_____

Date of Birth _____

For your well being you must inform us with all the medications that you are taking and any medical conditions.

A. ARE YOU

1. Attending or receiving any treatment from your doctor. hospital, clinic or specialist? YES / NO _____
2. Taking any medicines or tablets prescribed by your doctor? (please attach copy of repeat prescription) YES / NO _____
3. Allergic to penicillin or any other drug or substance? YES / NO _____
4. Pregnant or likely to be so? YES / NO _____

B. HAVE YOU

1. Ever had a heart problem, angina, high or low blood pressure, heart attack or stroke? YES / NO _____
2. Ever had rheumatic fever? YES / NO _____
3. Ever had Jaundice, hepatitis, liver problems or kidney disease? YES / NO _____
4. Ever had asthma, bronchitis or any serious chest infections? YES / NO _____
5. Ever had any blood refused by the blood transfusion service or blood related diseases? Eg. HIV or Hepatitis YES / NO _____
6. Ever had a bad reaction to local or general anaesthetic? YES / NO _____
7. Ever had an operation or received hospital treatment? YES / NO _____
8. Ever had a heart valve replaced? YES / NO _____
9. Ever been diagnosed as having CJD? (or has any member of your family) YES / NO _____

C. DO YOU

1. Have a pacemaker? YES / NO _____
2. Have fainting attacks, giddiness or epilepsy? YES / NO _____
3. Have diabetes? YES / NO _____
4. Have arthritis? YES / NO _____
5. Suffer from hayfever or eczema? YES / NO _____
6. Carry a warning card? YES / NO _____
7. Bruise easily or do you bleed excessively? YES / NO _____
8. Take or have you ever taken steroids? YES / NO _____
9. Drink? If so how much YES / NO _____
10. Smoke? If so how much YES / NO _____

Patient Signature: _____ Date: _____

Completed by (please tick) ☐ Self ☐ Parent ☐ Guardian ☐ Dentist