GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Community Dental Service
CONFIDENTIAL MEDICAL HISTORY

SURNAME	**FORENAMES**
DATE OF BIRTH	**MALE / FEMALE**
ADDRESS **PHONE numbers** **HOME:** **MOBILE:**	**DOCTOR'S NAME AND ADDRESS** **DOCTOR'S PHONE Number:**

ARE YOU CURRENTLY:	**YES**	**NO**	**DETAILS**
Receiving **treatmen**t from a doctor, hospital or clinic?			
Are you **Pregnant** or breastfeeding?			
Carrying a **warning card** or learning disability passport?			
Using a **mobility aid** such as a wheelchair, frame or stick?			

DO YOU HAVE ANY PROBLEMS WITH YOUR HEALTH:	**YES**	**NO**	**DETAILS**
HEART (e.g. heart attack, angina, heart murmur, pacemaker)			
BLOOD PRESSURE			
CHEST (e.g. asthma, COPD, bronchitis, shortness of breath)			
LIVER or KIDNEYS (e.g. hepatitis, cirrhosis, jaundice)			
BLEEDING DISORDER (e.g. anaemia, prolonged bleeding after cuts or dental extractions, bleeding disorder, bruise easily)			
STOMACH AND INTESTINES (e.g. ulcers, acid reflux)			
JOINTS AND BONES (e.g. arthritis)			
AN ALLERGY to any medication, food or materials (e.g. antibiotics, latex, first aid plasters or dressings)			
A STROKE **IF YES, HOW HAS THIS AFFECTED YOU?**			
SWALLOWING OR CHOKING PROBLEMS How does this affect you?			
A LEARNING DISABILITY, ADHD, AUTISTIC SPECTRUM DISORDER, ACQUIRED BRAIN INJURY?			
MENTAL HEALTH CONDITION			

(e.g. Anxiety, depression, schizophrenia)			
DO YOU/ HAVE YOU EVER HAD:	**YES**	**NO**	**DETAILS**
EPILEPSY, **FAINTING OR PANIC ATTACKS, FITS**			
PROBLEMS WITH YOUR SKIN (e.g. eczema, scleroderma)			
DIABETES OR THYROID PROBLEMS			
STEROIDS OR BISPHOSPHONATE MEDICATION			
HAD BAD REACTION TO GENERAL OR LOCAL ANAESTHESIA OR SEDATION			
HAD TREATMENT IN HOSPITAL AS AN IN-PATIENT (e.g. surgery, chemotherapy or radiotherapy)			
AN INFECTIOUS DISEASES (e.g. HIV, Hepatitis, TB, CJD)			
DO YOU HAVE ANY SPECIFIC SPECIAL CARE REQUIREMENT (e.g. Do you have a hearing or visual impairment or need a hoist to enable you to transfer? **Details below please**)			
PLEASE TELL US WHAT YOUR HEIGHT AND WEIGHT ARE IF YOU KNOW? **HEIGHT:** **WEIGHT:**			
	YES	**NO**	**quantity/day**
How many units of alcohol do you drink per week?			
Do you smoke any tobacco products?			
Do you chew betel/areca nut/other substances?			
PLEASE LIST ALL MEDICATIONS YOU ARE TAKING INCLUDING DOSE AND FREQUENCY **(e.g. tablets, inhalers, ointments, contraceptives, homeopathic remedies, supplements)**			

Completed by (circle): **Self Parent Carer Health Worker**	Signature	Date
Completed by : **Dentist**	Signature	Date