Guy's and St Thomas'
NHs Foundation Trust

Adult Medical History

Guys and St Thomas' Dental Hospital

Your medical history is important

Please complete this form so that we can deliver the best dental care for you.

Additional information can be written on the back of this form.

Patient Details (or label)

Hospital Number _____

NHS Number _____

Name _____

Date of Birth _____

	Yes	No
Are you in good health ?		
Have you had any operations or serious illnesses in the past ?		
Are you currently attending a doctor, hospital clinic, or specialist ?		
Could you be pregnant ?		

Do you have, or have you had, any problems with your:

	Yes	No	If yes, please give further details
Breathing e.g. asthma, COPD, shortness of breath or a persistent cough ?			
Heart e.g. heart attack, angina, murmur, a replacement valve, or pacemaker ?			
Blood pressure ?			
Blood e.g. anaemia, sickle cell disease, thalassemia, prolonged bleeding, or bruising ?			
Stomach or gut e.g. ulcers, gastric, reflux, or colitis ?			
Kidneys, bladder, or liver e.g. chronic infections, jaundice, or cirrhosis of liver ?			
Nervous system e.g. epilepsy, Parkinson's disease, multiple sclerosis, or a stroke ?			
Hormones e.g. diabetes or thyroid ?			
Joints and bones e.g. arthritis, osteoporosis ?			
Skin e.g. eczema or psoriasis ?			
Mental health e.g anxiety, depression, schizophrenia, bipolar, eating disorders ?			

Are you allergic to anything e.g. penicillin or any other drugs, or to latex, foods, or metals ?			
Have you ever had/having treatment for cancer e.g. chemotherapy or radiotherapy ?			
Could you have contracted an infection such as hepatitis, HIV, TB, or CJD ?			
Do you have a learning disability ?			
Do you have any physical disabilities e.g. wheelchair user, visual, or hearing ?			
Have you ever had sedation or a general anaesthetic ?			

Medication/Drugs

Are you taking any medication or drugs which are prescribed, or bought over the counter, or recreational ? **Yes** ☐ **No** ☐

If **yes**, please list them below, including dose and frequency	**Date started**	**Date stopped**

Smoking and drinking habits

	Yes	**No**	**Given up (date)**
Do you currently smoke or use any form of tobacco, e-cigarettes (vape), or shisha, or chew paan/arecanut ?			

If you smoke cigarettes, how many do you smoke a day ? ☐

How many years have you been smoking / chewing ? ☐

How many units of alcohol do you drink in an average week? _____

(1 unit = half a pint of beer/lager, a small glass of wine, or a single measure of spirits)

Further details (please add any relevant information)
Checked and signed by clinician

Print name							
Date							