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| **Guy’s and St Thomas’**  NHs Foundation Trust |

**Adult Medical History**

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| **Guys and St Thomas’ Dental Hospital**  Your medical history is important.  Please complete this form so 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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|  | **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:

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|  | **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 ? |  |  |  |

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|  | **Yes** | **No** |  | |
| Are you taking any medication or drugs which are prescribed, bought over the counter, or recreational ? |  |  | If yes, please list them below | |
| **Medication/Drugs**  (including dose and frequency) | | | **Date started** | **Date stopped** |
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**Smoking and drinking habits**

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

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| 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)

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| **Further details**  (please add any relevant information)  **Checked and signed by clinician** | | | | | | | | |
| Print name |  |  |  |  |  |  |  |  |
| Date |  |  |  |  |  |  |  |  |