OUTPATIENT DENTAL GENERAL ANAESTHETIC SERVICE

CONFIDENTIAL MEDICAL HISTORY (FORM 3)

Name of Patient …….. **Date of Birth** ……..... **Gender** …….**M**……..**F**…….
Family Doctor ……
Surgery …… **NHS No (Mandatory)** ……
…….. **Ethnicity** ……

Please tick all that apply

1. Has the patient a history of:	**YES**	**NO**
Heart problems and condition	☐	☐
High blood pressure	☐	☐
Rheumatic Fever	☐	☐
Anaemia	☐	☐
Bleeding or Blood Disorders	☐	☐
Sickle Cell / Thalassemia	☐	☐

2. Is the patient allergic to:	**YES**	**NO**
Penicillin	☐	☐
Other Antibiotics	☐	☐
Aspirin	☐	☐
Other Drugs	☐	☐
Latex / Rubber / Balloons	☐	☐
Food / Fruit	☐	☐

3. Has the patient a history of:	**YES**	**NO**
Liver Disease	☐	☐
Hepatitis / HIV / AIDS	☐	☐
Kidney Disease	☐	☐
Diabetes	☐	☐
Other Infections	☐	☐

4. Has the patient ever had:	**YES**	**NO**
Hay Fever	☐	☐
Asthma	☐	☐
Shortness of breath	☐	☐
Bronchitis / Pneumonia	☐	☐
Tuberculosis	☐	☐

5. Is the patient:	**YES**	**NO**
Pregnant	☐	☐
Obese / Overweight	☐	☐
Do you weigh over 20 stone (127 kg)	☐	☐
Blind / partially sighted	☐	☐
Deaf / hard of hearing	☐	☐

Please tick all that apply

	YES	**NO**
6a. Does the patient smoke?	☐	☐
How many Daily ……..		
Have you ever smoked	☐	☐

	YES	**NO**
6b. Does the patient Drink Alcohol?	☐	☐
How many units weekly? ……		

7. Has the patient any history of:	**YES**	**NO**
Epilepsy / convulsions	☐	☐
Any other serious illness	☐	☐

If yes, please give details……...
……
……

8. has the patient ever:	**YES**	**NO**
Been in hospital	☐	☐
Had an Operation	☐	☐
Had a General Anaesthetic (including tooth extraction)	☐	☐

If yes, please give details ……
……
……

9. Has the patient ever had mental health problems (including depression, anxiety, memory loss)	**YES**	**NO**
	☐	☐

If yes, please give details ……
……
……

10. Is the patient taking any medication, tablets or inhalers	**YES**	**NO**
	☐	☐

If yes, please give details below or on a separate sheet if necessary
……
……
……

Has the patient or anyone else in the family ever had problems associated with general anaesthesia?

If yes, please give details ……

Has the patient seen a doctor, a specialist or paediatrician during the last year?

If yes, please give details ……

Does the patient have a learning disability / learning support at school?

If yes, please give details ……

Is there anything else you think we should know that you feel might be important, including any specialist diagnosis?

If yes, please give details ……

Signed by …….. Dentist's Signature ……..

Patient/Parent/Legal Guardian …… Date ……