Guy's and St Thomas' NHS
NHS Foundation Trust

Adult Medical History

Guy's 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 the form.

Patient Details (or label)

Hospital 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 and 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?			

	Yes	No	
Are you taking **any** medications 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

Smoking and drinking habits

	Yes	Never	Given up (Date)
Do you currently smoke or use any form of tobacco, ecigarettes (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								