

confidential medical history form

Today's advances in dental techniques and materials means that we are now more than ever able to help you achieve the smile you've always wanted.

1. Are you satisfied with the appearance of your teeth?

Yes

No
2. Are you self conscious about your teeth when you smile?

Yes

No
3. Do you wish your teeth were whiter?

Yes

No
4. Do you wish your teeth were shaped differently?

Yes

No
5. Do you have any irregularly positioned teeth which you dislike?

Yes

No
6. Do you have any discoloured teeth which embarrass you?

Yes

No
7. Do your front teeth have fillings which do not match the colour of your teeth?

Yes

No
8. Do you wish the fillings in your back teeth were tooth coloured?

Yes

No
9. Do your gums appear red and swollen, and bleed when you brush them?

Yes

No

Medical History Update

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes.

Date	Patient Initials	Dentist Initials

Next of kin

Completed by (please tick)

Self

Parent

Guardian

Dentist

Signature

Date

Please provide us with information about your personal details and general health to help us treat you safely. Do not answer any questions you do not understand, you will have the opportunity to discuss any queries with your dentist who will be happy to answer any of your questions. All information will be kept strictly confidential by the people caring for you.

Surname

First Name

Title

Sex

Male

Female

DoB

day

month

year

Address

Postcode

Tel Home

Tel Work

Mobile

Email

Occupation

NHS No.

You will find your NHS No. here: www.connectingtohealth.nhs.uk/nhsnumber

Doctor's Name and Address

Doctor's Tel

Our Dental Practice may need to place/store your medical details on our computer system. This is for our internal use only. Please tick to give authorisation.



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Are you currently Pregnant?

Yes

No

Receiving treatment from a doctor, hospital or clinic?

Yes

No

Taking any prescribed medicines (eg tablets, ointments, injections, or inhalers, eyedrops, suppositories, nebulisers, the contraceptive pill or HRT)?

Yes

No

Carrying a medical warning card?

Yes

No

Do you suffer from

Details / Medication

Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?

Yes

No

Hay fever or eczema?

Yes

No

Bronchitis, asthma or other chest condition?

Yes

No

Fainting attacks, giddiness, blackouts, epilepsy?

Yes

No

Muscle problems (myopathy, dystrophy, paralysis)?

Yes

No

Heart problems, angina, blood pressure problems, or stroke?

Yes

No

Diabetes (or does anyone in your family)?

Yes

No

Neurological (nerve) diseases ('neuropathies', MS etc)?

Yes

No

Arthritis?

Yes

No

Bruising or persistent bleeding following injury, tooth extraction or surgery?

Yes

No

Any infectious diseases (including HIV, hepatitis, TB)?

Yes

No

Stomach ulcers/hiatus hernia/indigestion?

Yes

No

Did you, as a child or since, have

Details / Medication

Rheumatic fever, heart murmur or chorea?

Yes

No

Liver disease (eg jaundice, hepatitis)?

Yes

No

Kidney disease?

Yes

No

Any other serious illness?

Yes

No

Did you, as a child or since, have

Details

Blood refused by the Blood Transfusion Service?

Yes

No

A bad reaction to general or local anaesthetic?

Yes

No

A joint replacement or other implant?

Yes

No

Treatment that required you to be in hospital?

Yes

No

Heart surgery?

Yes

No

Brain surgery?

Yes

No

Growth hormone treatment before the mid 1980s?

Yes

No

A close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease (CJD)?

Yes

No

Steroid treatment?

Yes

No

Drinking

How many units of alcohol do you drink per week? (A unit is half a pint of lager, a single measure of spirits or a single glass of wine/apertif.)

units per week

Smoking and Chewing

Do you smoke any tobacco products now (or did you in the past)?

Yes

No

In past

times per week

Do you chew tobacco, pan, use qutkha or supari now (or did you in the past)?

Yes

No

In past

times per week

Oral Hygiene

How often do you brush your teeth

How often do you use any method of interdental cleaning

How often during the course of a day do you eat sugary snacks

times per day

How often during the course of a day do you have drinks containing sugar - inc sugar in tea and coffee

times per day

Please give any other details which your dentist might need to know about, such as self-prescribed medicines (eg aspirin).