PEARL DENTAL
DENTISTRY & AESTHETICS

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.

	YES	NO
1. Are you satisfied with the appearance of your teeth?	☐	☐
2. Are you self conscious about your teeth when you smile?	☐	☐
3. Do you wish your teeth were whiter?	☐	☐
4. Do you wish your teeth were shaped differently?	☐	☐
5. Do you have any irregularly positioned teeth which you dislike?	☐	☐
6. Do you have any discoloured teeth which embarrass you?	☐	☐
7. Do your front teeth have fillings which do not match the colour of your teeth?	☐	☐
8. Do you wish the fillings in your back teeth were tooth coloured?	☐	☐
9. Do your gums appear red and swollen, and bleed when you brush them?	☐	☐

10. Do you suffer from bad breath – halitosis? ☐ ☐

11. If you could alter your smile what would you most like to change?

_____

_____

12. On a scale of 1 - 10 how happy are you with your smile

1 2 3 4 5 6 7 8 9 10

Which of the following statements best describes your feelings about visiting the dentist? Tick the one you agree with.

☐ *I feel relaxed*

☐ *I feel a little anxious*

☐ *I feel very anxious and nervous*

Are there any dental procedures which have frightened you in the past, or which you are very anxious about?

_____

_____

_____

13. Would you like to receive further information regarding wrinkle reduction and facial fillers? ☐

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	LIST OF ANY CHANGES	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.connectingforhealth.nhs.uk/nhsnumber***

Doctor's Name _____

Address _____

_____

_____ Postcode _____

_____

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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CONFIDENTIAL MEDICAL HISTORY FORM

ARE YOU CURRENTLY	YES	NO	DETAILS/ MEDICATION
Pregnant?	☐	☐	
Receiving treatment from a doctor, hospital or clinic?	☐	☐	
Taking any prescribed medicines *(eg tablets, ointments, injections, or inhalers, eyedrops, suppositories, nebulisers, the contraceptive pill or HRT)?*	☐	☐	
Carrying a medical warning card?	☐	☐	

DO YOU SUFFER FROM	YES	NO	DETAILS/ MEDICATION
Allergies to any medicines *(eg penicillin), substances (eg latex/rubber) or foods?*	☐	☐	
Hay fever or eczema?	☐	☐	
Bronchitis, asthma or other chest condition?	☐	☐	
Fainting attacks, giddiness, blackouts, epilepsy?	☐	☐	
Muscle problems *(myopathy, dystrophy, paralysis)?*	☐	☐	
Heart problems, angina, blood pressure problems, or stroke?	☐	☐	
Diabetes *(or does anyone in your family)?*	☐	☐	
Neurological *(nerve)* diseases *('neuropathies', MS etc)?*	☐	☐	
Arthritis?	☐	☐	
Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐	☐	
Any infectious diseases *(including HIV, hepatitis, TB)?*	☐	☐	
Stomach ulcers/hiatus hernia/indigestion?	☐	☐	

DID YOU, AS A CHILD OR SINCE, HAVE	YES	NO	DETAILS/ MEDICATION
Rheumatic fever, heart murmur or chorea?	☐	☐	
Liver disease *(eg jaundice, hepatitis)*?	☐	☐	
Kidney disease?	☐	☐	
Any other serious illness?	☐	☐	

DID YOU, AS A CHILD OR SINCE, HAVE	YES	NO	DETAILS
Blood refused by the Blood Transfusion Service?	☐	☐	
A bad reaction to general or local anaesthetic?	☐	☐	
A joint replacement or other implant?	☐	☐	
Treatment that required you to be in hospital?	☐	☐	
Heart surgery?	☐	☐	
Brain surgery?	☐	☐	
Growth hormone treatment before the mid 1980s?	☐	☐	
A close relative *(parent, sibling, child, grandparent or grandchild)* with Creutzfeldt Jakob Disease (CJD)?	☐	☐	
Steroid treatment?	☐	☐	

DRINKING

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

SMOKING AND CHEWING	YES	NO	IN PAST	
Do you smoke any tobacco products now *(or did you in the past)?*	☐	☐	☐	_____ *times per week*
Do you chew tobacco, pan, use gutka or supari now *(or did you in the 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).*