Confidential medical history

Like all dentists we ask for information regarding your general health to help us treat you safely. Please complete both sides of this form and sign. All information is kept strictly confidential.

Full name ..... DOB .....

Address .....

..... Postcode .....

Daytime tel ..... Evening .....

Mobile ..... Email .....

Can we send you appointment reminders by text and email? Yes ☐ No ☐

Sex (please tick) male ☐ female ☐ Occupation .....

Doctor's name, address and telephone .....

.....

Details of person to contact in an emergency:

Name..... Daytime tel .....

Are you under medical care or been in hospital for anything? Yes ☐ No ☐

Are you taking any pills, potions, lotions, infusions or using an inhaler? Yes ☐ No ☐ If yes,

please list. (please write on an extra sheet if necessary) .....

.....

Are you in any private medical scheme that allows full/part refund of dental charges? If yes,

please give details .....

Have you had any of the following? (please tick all that apply)

- ☐ Rheumatic fever
- ☐ Congenital heart lesion/pacemaker
- ☐ Heart condition/angina
- ☐ High or low blood pressure
- ☐ Stroke
- ☐ Diabetes
- ☐ Epilepsy, fits, fainting attacks
- ☐ Joint or valve replacement
- ☐ Jaundice, hepatitis, liver disease
- ☐ Infectious diseases incl. HIV
- ☐ Bronchitis, asthma, chest conditions
- ☐ Prolonged bleeding/bruising problems
- ☐ A medical warning card
- ☐ Allergies (please specify) .....

- ☐ Do you think you may be pregnant?
- ☐ Have you had a baby in the last year?
- ☐ Do you have problems climbing stairs?
- ☐ Have you been treated for osteoporosis?
- ☐ Do you suffer from cold sores?
- ☐ Have you ever had a close relative with CJD?
- ☐ Have you ever had an operation?

(please specify) .....

When was the last time you visited a dentist .....

When did you last have x-rays on your teeth? .....

Are you a nervous patient? (Please circle one of the boxes below).

1 equals not nervous and 5 equals very nervous. 1 2 3 4 5

Do you smoke? Yes ☐ No ☐ If yes, how many a day? .....

Do you drink alcohol? Yes ☐ No ☐ If yes, how many units a week? .....

Do you drink fizzy drinks? Yes ☐ No ☐ If yes, how many drinks a week? .....

Are you having any discomfort with your teeth at the moment? Yes ☐ No ☐

Do you have any bleeding from your gums? Yes ☐ No ☐

Do you sometimes suffer from bad breath? Yes ☐ No ☐

Do you have an unpleasant odour or taste in your mouth? Yes ☐ No ☐

Do you suffer from dry mouth? Yes ☐ No ☐

Do you have any marks or lumps in your mouth or on your lips? Yes ☐ No ☐

Does your jaw click, pop, lock or make any noise on opening or closing? Yes ☐ No ☐

Do you have frequent headaches? Yes ☐ No ☐

Do you grind or clench your teeth or been told you do? Yes ☐ No ☐

Do you have a history of trauma to your chin or jaw? Yes ☐ No ☐

Are you happy with the appearance of your teeth? Yes ☐ No ☐

If no, what would you like to improve? .....

Have you had any particular problem with dental treatment in the past? Yes ☐ No ☐

If yes, can tell us what it was? .....

Is there anything else about your teeth you would like to discuss? Yes ☐ No ☐

If yes, please give details .....

How did you hear about us? Web ☐ Phone book ☐ Word of mouth ☐ Passing by ☐

Other (please specify) .....

Completed by: Self ☐ Parent ☐ Guardian ☐

Signature

Date

Medical history update (practice use only)

Date	Any change?	List any changes below	Pt's signature
.....	.....	.....	.....
.....	.....	.....	.....