Dawley Dental Practice

Confidential Medical History Form

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

We will ask you to complete a new Medical history form every 18-24 months to ensure all details are current.

Surname	**First Name**

Title	**Sex Male / Female**	**D.O.B**

Address **Postcode**

Tel Home	**Tel Work**
Mobile	**Email**

Occupation
Doctor's Name & Address

Next of Kin : Name: **Relationship :**	**Next of Kin Contact number:**

Are you currently	**YES**	**NO**	**If ticked "YES" please give details**
Pregnant?			
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medication?			Please list all medication overleaf
Taking / ever taken bisphosphonates (eg alendronic acid or zoledronic acid?			
Taking warfarin or anticoagulation medication?			
Do you suffer from Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?			
Bronchitis, asthma or other chest conditions?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart problems, angina, blood pressure problems, stroke or pacemaker? Or ever had heart surgery?			
Diabetes			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases (including HIV, hepatitis, TB)?			
Stomach ulcers / hiatus hernia / indigestion?			
Osteoporosis or other bone related condition?			
Did you, as a child or since, have Kidney disease or Liver disease (eg jaundice, hepatitis)?			
Any other serious diseases?			
A bad reaction to general or local anaesthetic?			
Treatment that required you to be in hospital?			
Steroid Treatment?			

PLEASE TURN OVER

How many units of alcohol do you drink per week? (A unit is half a pint of lager, a single measure of weak spirits or a small 175ml glass of wine)		Units Per Week

Smoking and Chewing	**YES**	**NO**	**If ticked "YES" how much and for how long?**
Do you currently smoke/chew tobacco?			
Have you ever smoked/chewed tobacco?			
Do you/have you ever used e-cigarettes?			

Please list all prescribed medication here

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

If you are a new patient, where did you last receive dental treatment and when?
If you are a new patient, how did you hear about the practice?

Completed by	**Self**	**Parent**	**Guardian**	**Dentist**
(tick box)				

Signature.....

Date .....

Do you suffer with Migraines, tooth clenching or grinding?	**Yes**	**No**
If yes please state which & severity of symptoms;		

The rest of this form is optional to complete

On a scale of 1-10, how happy are you with your smile? Please circle.

Not happy at all ☹ - 1 2 3 4 5 6 7 8 9 10 – ☺ Very happy

If you are not happy with your smile please explain why;

	Yes	**No**
Would you be interested in facial aesthetics? E.g. Botox/facial fillers?		
If yes would you like a free consultation?		

Dentist Signature: .....

PLEASE TURN OVER