Dawley Dental Practice

Confidential Medical History Form

All information will be kept strictly confidential by the people caring for you. Please ask if you are unsure of anything.

Surname	**First Name**	
Title	**D.O.B**	**Please state gender:**
Contact number	**Email address**	
Address		
Doctor's Name & Practice	**Your occupation**	
Next of Kin name: **Relation to you:**	**Next of kin contact:**	

Marketing options contact preferences (please tick)	**Mail**	**Email**	**Text**	**Phone**
Marketing options would you like to hear about (please tick)	**Product & service information or promotions**	**Newsletters**	**Important notifications**	

Are you currently	**YES**	**NO**	**If ticked "YES" please give details**
Pregnant? (Please advise us if you are breastfeeding)			
Receiving treatment from a doctor, hospital or clinic?			
Taking or taken bisphosphonates (eg alendronic acid or zoledronic acid?			
Taking warfarin or anticoagulation medication?			
Do you suffer from or ever had 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?			
Kidney disease or Liver disease (eg jaundice, hepatitis)?			
A bad reaction to general or local anaesthetic?			
Steroid Treatment?			
Any other serious illnesses or diseases?			

Please list ALL prescribed and self prescribed (eg aspirin) MEDICATIONS here: *we can use your repeat prescription*

	NO	**YES – How much?**
Do you currently smoke/chew tobacco?		
Have you ever smoked/chewed tobacco?		
Do you drink alcohol regularly each week?		

How often do you brush?	
Do you use a manual or electric toothbrush?	

Signed		**Completed by**	**Carer/ Guardian**	**Self**	**Dentist**
Date		**(tick box)**			

Dentist use ONLY
Dentist initial:

The rest of this form is optional to complete New patients

Where and when did you last receive dental treatment?
How did you hear about the practice?

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?		
Would you like to receive facial aesthetics offers?		
Would you be interested in whitening your teeth?		
Would you be interested in straightening your teeth?		
Would you like to change your silver fillings to white fillings?		