Confidential Medical History Questionnaire

Welcome to Smile Dental Care

In order to help us meet all of your dental health care needs, please complete the following Medical History Form. Please ask a member of our team if you need any assistance or have any questions.

Personal Details

Title: Mr ☐ Mrs ☐ Ms ☐ Ms ☐ Other ☐ Sex: ☐ M ☐ F

Full Name | D.O.B | Home Tel. | Work Tel.

Email Address | Occupation | Mobile Tel.

Address | Post Code

How would you prefer to receive correspondence from Smile Dental Care?

☐ By email ☐ By post ☐ By SMS

Approx. date of last dental visit?

Doctor's Details

Name and Address | Contact Tel.

Medical History - Do you Have or Have you Had any of the Following?

	Yes	No		Yes	No
Anaemia			Heart condition or heart attack/ heart murmur/ angina		
Diabetes			Rheumatic fever or Chorea/ St Vitus Dance		
Epilepsy			Liver or kidney problems including hepatitis/ jaundice		
Cancer			TB or chest problems including asthma/ bronchitis		
Brain surgery			A joint replacement or other implant		
Arthritis			Bad reaction to local or general anaesthetic		
Cold sores			Blood refused by the Blood Transfusion Service		
Gastric disease			Treatment that required you to stay in hospital		
Drug dependence			Please tick or tell your dentist if you are HIV positive		
High or low blood pressure			**Women only:**		
Fainting attacks/ giddiness/ blackouts			Are you taking the contraceptive pill		
Headaches/ migraines			Are you pregnant		

Are you allergic to any medicines, tablets, substances or latex? If so, which?

Do you smoke? If so, how many cigarettes do you smoke on average in a week?

On average, how many units of alcohol do you drink in a week?

Please provide further details on any of the above medical problems and/or any medication you are currently taking:

Please turn over »

Dental history - do you have or have you had any of the following?

	Yes	No		Yes	No
Pain or discomfort in your teeth	☐	☐	Unpleasant taste/ odour in your mouth	☐	☐
Sensitivity in your teeth	☐	☐	Food often stuck between teeth	☐	☐
Bleeding when brushing/ flossing	☐	☐	Mouth ulcers/ cold sores	☐	☐
Headaches/ migraines	☐	☐	Grinding teeth/ clenching jaw	☐	☐

Making the most of your smile - can we help you with any of the following?

	Yes	No		Yes	No
Stained/ discoloured teeth	☐	☐	Missing teeth	☐	☐
Uneven teeth/ gaps	☐	☐	Crossed over/ crooked teeth	☐	☐
Unsightly/ black fillings	☐	☐	Uncomfortable dentures	☐	☐
Cracked/ transparent teeth	☐	☐	Bad breath	☐	☐

Please provide further details about any concerns you may have with your smile

How did you hear about us? (If referred, please state by whom)

☐ In passing ☐ Advert ☐ Web ☐ Family/ friend ☐ Referral ☐ Other _____ Please provide further details

Signature

Please sign below to certify that you have read and understood the above information and that all of your answers are accurate and up-to-date. Any incorrect information can be dangerous to your health and you must inform us of any changes.

	/ /		/ /
Patient/ Parent/ Guardian	Date	Dentist	Date

Medical History Form Updates (For Follow-up Appointments)

Please sign below to certify that the information in this Medical History Form is still accurate and up-to-date. If there are any changes in your health, please provide us with details.

	/ /	
Patient/ Parent/ Guardian	Date	Please either state 'No Changes' or provide details of changes
	/ /	
Patient/ Parent/ Guardian	Date	Please either state 'No Changes' or provide details of changes
	/ /	
Patient/ Parent/ Guardian	Date	Please either state 'No Changes' or provide details of changes

Thank you for choosing Smile Dental Care. We are proud to grow our practice through referrals - as a valued patient of our practice, please ensure you recommend us to your family, friends and colleagues.