MEDICAL HISTORY

Surname (Mr/Mrs/Miss/Ms) _____ Date of Birth: _____

Forename _____ Doctors name and address:

Address _____ _____

Postcode_____ Email: _____ _____

Home tel: _____ Mobile:_____ _____

	Yes	No
Are you attending or receiving treatment from a doctor, hospital, or any specialist?		
Are you taking any medicines prescribed by your doctor or other?, tablets, creams, ointments, injections etc? If so please list in the section below.		
Are you taking or have taken steroid in the last 2 years?		
Do you have any allergy to penicillin or other drugs, foods, or medicines?		
Do you suffer from hay fever, eczema or any other allergy?		
Do you have asthma, COPD or any chest condition? If so what medication?		
Do you have lung disease, shortness of breath, heart problems, mumur, angina, raised blood preasure, stroke or have a pacemaker?		
Do you have arthritis? Osteoporosis?		
Do you have diabetes or does anyone in your family?		
Do you have giddiness, panic attacks, blackouts, or epilepsy?		
Do you have a medical warning card?		
Have you ever been hospitalised for an operation or serious illness?		
Have you ever had rheumatic fever or chorea?		
Have you ever had jaundice, liver disease or Hepatitis?		
Have you ever had cause to believe you may be infected with HIV or hepatitis or TB?		
Do you suffer from sickle cell, bleeding disorders, haemophilia, on anticoagulants?		
Do you suffer from cold sores?		
Do you bleed excessively following a tooth extraction, surgery, or injury?		
Do you have a bad reaction to local or general anaesthetic?		
Are you pregnant?		
Do you smoke: If so how much?		
Do you drink alcohol? If so how many units?		

Additional Notes and Medications:

_____

_____

Please indicate if you are interested in the following types of dental treatment:

☐	Replacing silver fillings or ugly crowns	☐	Bad Breath
☐	Seeing the dental hygienist	☐	Replace missing teeth/Implants
☐	Tooth whitening	☐	Straighter Teeth

Other (please specify) _____

DENTAL HISTORY

Do you use an electric/manual toothbrush? _____

How many times do you-brush? _____

How many times do you floss? _____

Do you have many sugary or acidic foods/drinks?_____

If so, what do you have and how much? _____

Name of previous dentist?_____ _____

What was the date of your last visit? _____

Do you have any dental problems now (please specify)? _____

Are you nervous/anxious of dental treatment? _____

Are you happy for us to take photos if necessary and use for dental education or on our website?

YES..... NO..... ONLY IF ANONYMISED.....

Are you happy to receive emails and text messages to remind you of your next appointment?
Yes / No

Are you exempt from NHS dental charges? (please give reasons for exemption)? _____

Next of kin name, address and phone number:_____

_____

Where did you find out about us?_____

Do you think there are any other aspects concerning your health that your dentist should know?

_____

Thank you for filling out your patient form. We look forward to seeing you soon!

TruSmile Dental.