CONFIDENTIAL MEDICAL HISTORY FORM

Where did you learn about the practice?.....

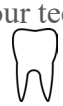
SURNAME …….....FIRST NAME …….
TITLE …….. Sex M [ ] F [ ] D.O.B ……..
ADDRESS……
POST CODE ……HOME NUMBER …….
MOBILE……..... E-MAIL.....……...
Occupation ……

DOCTORS NAME …… TELEPHONE …….
ADDRESS ……

NEXT OF KIN (name & contact number).....

Smile and facial aesthetic Questionnaire
(please circle)

- Do you have concerns about your breath? **Yes** **No**
- Would you be interested in tooth whitening? **Yes** **No**
- Are you concerned with crooked or crowded teeth? **Yes** **No**
- Would you like to improve the look of your smile? **Yes** **No**
- Do you get food trapped between your teeth? **Yes** **No**
- Do your gums bleed when you brush your teeth? **Yes** **No**



I understand and agree to the following practice policies:

- ✓ That the agreement by which I will be given dental treatment (my treatment plan) is an agreement between the dentist and me.
- ✓ That under my Treatment Plan, my treatment will have to be paid for in total by the last visit.
- ✓ That under my Treatment Plan, I may be required to pay in advance for certain items of treatment.
- ✓ That under my Treatment Plan, I may be charged a fee of £15 for each 15 minutes of an appointment missed or cancelled without 24 hours prior notice for **private** dental visits and half the hygiene fee for **hygienist** visits.
- ✓ That if I miss more than two **NHS** appointments without giving 24 hours required notice it will result in no longer being seen at the practice.

Signed……..**Date**……..

Please complete the questionnaire overleaf

Practice use only

Medical History checked

Dentist..... Date ..... Signed.....
Dentist..... Date ……..... Signed.....
Dentist..... Date ……..... Signed.....

(please circle)

Have you:

1.	Had rheumatic fever or chorea?	**Yes**	**No**
2.	Had jaundice, liver, or kidney disease?	**Yes**	**No**
3.	Had any infectious diseases (including Hepatitis & HIV)	**Yes**	**No**
4.	Ever been told you have a heart murmur or heart problems, Angina, blood pressure problems or a heart attack?	**Yes**	**No**
5.	Had any blood tests? If so what for?	**Yes**	**No**
6.	Ever had your blood refused by the blood transfusion service?	**Yes**	**No**
7.	Had a reaction to general or local anesthetic?	**Yes**	**No**
8.	Had a joint replacement?	**Yes**	**No**
9.	Been hospitalized within last 2years? If so what for and when?	**Yes**	**No**
10.	Are you receiving treatment from hospital/doctor/specialist?	**Yes**	**No**

If the answer is <u>YES</u> to any of the above please give details:……
……
……

Do You:

1.	Have arthritis or joint problems?	**Yes**	**No**
2.	Have a pacemaker, or have you had any heart surgery?	**Yes**	**No**
3.	Suffer from hay fever, eczema or any other allergy?	**Yes**	**No**
4.	Suffer from bronchitis, asthma or any chest conditions?	**Yes**	**No**
5.	Have fainting attacks, blackouts or epilepsy?	**Yes**	**No**
6.	Have diabetes or does anyone in your family?	**Yes**	**No**
7.	Have any bleeding disorders?	**Yes**	**No**
8.	Carry a warning card?	**Yes**	**No**
9.	Ever get cold sores?	**Yes**	**No**
10.	Do you think you may be pregnant?	**Yes**	**No**

If the answer is <u>YES</u> to any of the above please give details: …….
……

Do you smoke? **Yes** **No** If **yes** how many a day? **1-10** **11-20** **21-30** **30+**
Do you drink Alcohol? **Yes** **No** (weekly) **1-8units** **9-12units** **13-19units** **20+**
Due to our chairs weight limit are you over 20 stone? **Yes** **No**

Are you:

- Taking or taken Steroids in the last two years? **Yes** **No**
- Allergic to any medicines, food or materials? Ie: Latex, Penicillin **Yes** **No**

If <u>allergic</u>, what to:……

Taking any medicines, tablets, creams, ointment, injections etc? **Yes** **No**
If **<u>YES</u>** please list all below:

Name of Medicines	**Dose**

Are there any other aspects of your health that you think the dentist should know about?

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