CONFIDENTIAL MEDICAL HISTORY FORM

For your well being you must inform us of any medical changes that have occurred since your last visit.

Please ensure that you keep us up to date with all the medications that you are taking.

Confidential medical history

A. ARE YOU

1. Attending or receiving any treatment from your doctor. hospital, clinic or specialist? YES / NO _____
2. Taking any medicines or tablets prescribed by your doctor? (please attach copy of repeat prescription) YES / NO _____
3. Allergic to penicillin or any other drug or substance? YES / NO _____
4. Pregnant or likely to be so? YES / NO _____

B. HAVE YOU

1. Ever had a heart problem, angina, high or low blood pressure, heart attack or stroke? YES / NO _____
2. Ever had rheumatic fever? YES / NO _____
3. Ever had Jaundice, hepatitis, liver problems or kidney disease? YES / NO _____
4. Ever had asthma, bronchitis or any serious chest infections? YES / NO _____
5. Ever had any blood refused by the blood transfusion service or blood related diseases? Eg. HIV or Hepatitis YES / NO _____
6. Ever had a bad reaction to local or general anaesthetic? YES / NO _____
7. Ever had an operation or received hospital treatment? YES / NO _____
8. Ever had a heart valve replaced? YES / NO _____
9. Ever been diagnosed as having CJD? (or has any member of your family) YES / NO _____

C. DO YOU

1. Have a pacemaker? YES / NO _____
2. Have fainting attacks, giddiness or epilepsy? YES / NO _____
3. Have diabetes? YES / NO _____
4. Have arthritis? YES / NO _____
5. Suffer from hayfever or eczema? YES / NO _____
6. Carry a warning card? YES / NO _____
7. Bruise easily or do you bleed excessively? YES / NO _____
8. Take or have you ever taken steroids? YES / NO _____
9. Drink alcohol? If so, how many units of alcohol do you consume per week? YES / NO _____
10. Smoke? If so, how many cigarettes or cigars do you smoke per day or per week? YES / NO _____

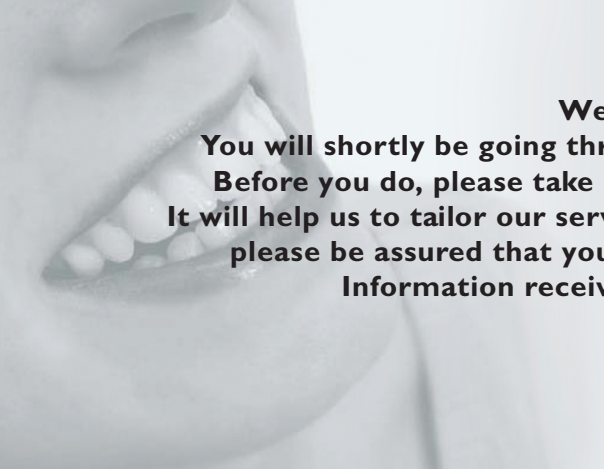
Patient Signature: _____ Date: _____

Completed by (please tick) ☐ Self ☐ Parent ☐ Guardian ☐ Dentist

MEDICAL HISTORY UPDATE	Date	No Change	Patient Signature	Dentist Signature
Please check that the health information on this form is still correct (including information on smoking and drinking). Please amend as necessary.				

Hoddesdon DENTAL SURGERY

www.hoddesdondental.com



Welcome to our Dental Surgery
You will shortly be going through to see your dentist for your dental examination
Before you do, please take a few moments to answer the questions on this form.
It will help us to tailor our services to your requirements. Should you have any queries please be assured that your dentist will be available to discuss these with you.
Information received will be treated with strictest confidence.

How did you hear of us?

Like all dentists, we ask patients for information about their general dental health to help us treat them safely. Please write your contact details below and answer the health questions on the back page. We will show you the form at later visits so that you can tell us whether there has been any change in you general health.

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Surname

Forename

Address

Work Number

Home Number

Mobile Number

Email

Date of birth

Occupation

NHS Number

Doctors Name

Doctors Address

When did you last visit a dentist?

Which of the following statements best describes your feelings about visiting the dentist? Tick the one you agree with.

- ☐ I feel relaxed
- ☐ I feel a little anxious
- ☐ I feel very anxious and nervous

Are there any dental procedures which have frightened you in the past, or which you are very anxious about?

Have you left another practice in order to come here? ☐ Yes ☐ No
If you think it is important to explain why, please do so

We hope you will be very satisfied with the care you receive in our Practice. We would like to know what made you choose us. Were any of the following reasons involved?

- ☐ Convenient location
- ☐ I was recommended by a friend
- ☐ Convenient surgery hours
- ☐ Family member already a patient here
- ☐ For emergency treatment only
- ☐ Referred by another dentist
- ☐ Located from Yellow Pages
- ☐ Located from our website
- ☐ Another reason, please specify

Smile check

Nowadays - thanks to tremendous advancements in dental techniques and material used - we really can help you to achieve the smile youíve always desired.

		Yes	No
1.	Are you satisfied with your teeth and their appearance?	☐	☐
2.	Are you self conscious about your teeth when you smile?	☐	☐
3.	Do you wish your teeth were whiter?	☐	☐
4.	Do you wish your teeth were shaped differently?	☐	☐
5.	Do you have any irregularly positioned teeth which you dislike?	☐	☐
6.	Do you have any discoloured teeth which embarrass you?	☐	☐
7.	Do your front teeth have fillings that do not match the colour of your teeth	☐	☐
8.	Do you wish the fillings in your back teeth were tooth coloured instead of black?	☐	☐
9.	Do your gums appear red and swollen, and bleed when you brush them?	☐	☐
10.	Do you suffer from bad breath - halitosis?	☐	☐
11.	Do you have any gaps or missing teeth that concern you?	☐	☐
12.	If you could alter your smile what would you most like to change?		