

Confidential medical history questionnaire

Welcome

Welcome to City Dental, in order to help us meet all of your dental healthcare needs, please complete the following confidential medical history form. Please ask a member of our team if you need any further assistance or have any questions.

Personal details

Title Mr Mrs Miss Ms Sex M F

Full name D.O.B Home Tel.

Email address Occupation Mobile Tel.

Please tick this box if you would prefer us not to contact you via email with special offers that we believe may be of interest to you

Home address Work address Work Tel. Number

Post code: Post code: Approx. date of your last dental visit

Doctor's details

Name Contact tel.

Address Post code

Medical history - do you have or have you had any of the following:

	Yes	No		Yes	No
Anaemia?	<input type="checkbox"/>	<input type="checkbox"/>	Liver or kidney problems including hepatitis/ jaundice?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding after cuts, bruises or tooth extraction?	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	Blood refused by the Blood Transfusion Service?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	A joint replacement or other implant?	<input type="checkbox"/>	<input type="checkbox"/>
Brain surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Fainting attacks/ giddiness/ blackouts?	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/ migraines?	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever?	<input type="checkbox"/>	<input type="checkbox"/>	Reaction to local or general anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>
Back trouble?	<input type="checkbox"/>	<input type="checkbox"/>	Treatment that required you to stay in hospital?	<input type="checkbox"/>	<input type="checkbox"/>
Eczema?	<input type="checkbox"/>	<input type="checkbox"/>	Please tick or tell your dentist if you are HIV positive	<input type="checkbox"/>	<input type="checkbox"/>
Or any of the following:	Yes	No	Do you have any close relatives with Creutzfeldt Jakob Disease?	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition including heart attack/ heart murmur/ angina?	<input type="checkbox"/>	<input type="checkbox"/>	Do you chew tobacco/ pan/ use gutkha or supari now (or have you in the past)?	<input type="checkbox"/>	<input type="checkbox"/>
High or low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Growth hormone treatment before the mid 80's?	<input type="checkbox"/>	<input type="checkbox"/>
TB or chest problems including asthma/ bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>			
Rheumatic fever or Chorea/ St Vitus' Dance?	<input type="checkbox"/>	<input type="checkbox"/>			

Your medical history continued...

If you answered yes to any of the previous questions overleaf, please provide further details. If you would like any additional note paper, please ask a member of our team.

If you are a smoker, how many cigarettes do you smoke on average in a week?

On average, how many units of alcohol do you drink in a week?
(1 standard size glass of wine is approx. 2 units and 1 pint of beer is approx. 3 units)

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

Please provide details of any medication you are taking

Female patients only

Are you pregnant?

Yes No

Are you taking the contraceptive pill?

Yes No

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

	Yes	No		Yes	No
Pain or discomfort in your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Unpleasant taste/ odour in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity in your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Food often stuck between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding when brushing/ flossing?	<input type="checkbox"/>	<input type="checkbox"/>	Mouth ulcers/ cold sores?	<input type="checkbox"/>	<input type="checkbox"/>

Can we help you with any of the following?

At City Dental, we offer a comprehensive range of cosmetic treatments to help you make the most of your image:

Stained/ discoloured teeth	<input type="checkbox"/>	Missing teeth	<input type="checkbox"/>
Uneven teeth/ gaps	<input type="checkbox"/>	Crossed over/ crooked teeth	<input type="checkbox"/>
Unightly fillings	<input type="checkbox"/>	Bad breath	<input type="checkbox"/>
Cracked/ transparent teeth	<input type="checkbox"/>	Facial appearance	<input type="checkbox"/>

How happy are you with the appearance of your smile?

Very happy Happy Fairly happy Unhappy Very unhappy Indifferent

How did you find out about us?

Internet In passing Friend/colleague Company Other If family/ friend, please provide their name

Signature

Cancellation & missed appointments

Should you need to change your appointment time or date, we simply ask for at least 2 business days notice, failure to do this may incur a charge.

I certify I have read and understood all information provided and have answered all questions accurately. I understand that any incorrect information can be dangerous to my health and I will inform my dentist of any changes. I understand the City Dental Cancellation and Missed Appointment Policy. I agree to be responsible for the payment in full of any service rendered on my behalf.

Patient

Date

Dentist

Date