Medical History Form

To obtain the best and safest treatment for you, your dentist needs to know all aspects of your health which may affect your treatment. Please complete this form, which your dentist will discuss fully with you before commencing treatment. If you have any questions, please ask your dentist. Additional notes may be written on the back. All information will be kept completely confidential. Thank you for your cooperation.

Surname:	Forenames:
Date of Birth:	Male/Female (please circle)
Address:	Occupation:
	Telephone Home:
Postcode:	Telephone Work:
Email Address:	Telephone Mobile:
Doctor's Name & Address:	Doctor's Telephone:

ARE YOU CURRENTLY:	YES	NO	IF YES, PLEASE GIVE DETAILS
Receiving treatment from a doctor, hospital or clinic?			
Taking any regular/prescribed medication?			
Taking or have taken steroids in the last 2 years?			
Pregnant or possibly pregnant?			
Carrying a medical warning card?			

HAVE YOU:	YES	NO	IF YES, PLEASE GIVE DETAILS
Allergies to any medicines (e.g. antibiotics), substances (e.g. latex/rubber) or foods?			
Heart problems, angina, blood pressure problems, stroke or pacemaker?			
Heart Surgery?			
Diabetes? (or does anybody in your family?)			
Hay fever or eczema?			
Asthma, bronchitis or other chest condition?			
Fainting attacks, giddiness, blackouts or epilepsy?			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases including HIV or hepatitis?			
A bad reaction to general or local anaesthetic?			
Rheumatic fever or chorea (St Vitus Dance)?			
Liver disease (e.g. Jaundice, hepatitis) or kidney disease?			
Any other serious illness or infectious disease?			
Blood refused by the Blood Transfusion Service?			
Bone or joint disease?			
A joint replacement or other implant?			

SMOKING	YES	NO	HOW MANY?
Do you smoke?			
Have you smoked in the past?			
Do you chew tobacco, pan or supari now, or in the past?			
ALCOHOL			
How many units of alcohol do you drink per week? (A unit is half pint of lager, single measure of spirits, a small glass(125ml) of wine. 3 units for a large glass(250ml) of wine):			

Have you had any other serious illness we have not asked you about?	
Are there any other aspects concerning your health that you think we should know about?	

Would you like to know more about any of the following?	YES	NO
Teeth whitening		
Sports guards/gum shields		

Next of kin: Name:	Relationship:
Tel: Home	Tel: Mobile

Do you consent to receiving a reminder for appointments and recalls by text and/or letter?	Yes/No

		Date
Signature		
Signature		
Signature		
Signature		
Signature		
Signature		

Completed by: Self/Parent/ Guardian (Please circle)

GUM DISEASE RISK ASSESSMENT

Gum disease will affect almost everyone at some stage in their life. This short questionnaire can help us find the best way to help you prevent this. **Instructions: Circle all answers that apply**

Age: ……. **Gender**: …….

Risk Factors	At Risk	Low Risk
Do you smoke?	YES	NO
Are you diabetic?	YES	NO
Are you on any medications?	YES	NO
Do you suffer from stress?	YES	NO
Are you pregnant?	YES	NO
Is there a family history of gum disease?	YES	NO
Do your gums bleed when brushing?	YES	NO
Do you have red gums, rather than the usual pink colour?	YES	NO
Do you have puffy or swollen gums?	YES	NO

You play a vital role in maintaining the health of your gums.

To help maintain healthy gums you should have a daily oral care routine. Please write a brief explanation below of the products you use and the frequency, e.g., toothbrushing twice a day with a branded toothpaste:

Thank you for filling out this form, this will help the team to care for your teeth and gums.