CROUCH STREET DENTAL SURGERY

Confidential Medical History Questionnaire

Welcome to Crouch Street Dental Surgery

In order to help us meet all of your dental health care needs, please complete the following Medical History Form.
Please ask a member of our team if you need any assistance or have any questions.

Personal Details

Title: Mr ☐ Mrs ☐ Ms ☐ Ms ☐ Other ☐ Sex: ☐ M ☐ F

Full Name | D.O.B | Home Tel. | Work Tel.

Email Address | Occupation | Mobile Tel.

Address | Post Code

How would you prefer to receive correspondence from our practice?
☐ By email ☐ By post ☐ By SMS

Approx. date of last dental visit?

Doctor's Details

Name and Address | Contact Tel.

Medical History - Do you Have or Have you Had any of the Following?

	Yes	No		Yes	No
Anaemia			Heart condition or heart attack/ heart murmur/ angina		
Diabetes			Rheumatic fever or Chorea/ St Vitus Dance		
Excessive bleeding			Liver or kidney problems including hepatitis/ jaundice		
Any Disability			TB or chest problems including asthma/ bronchitis		
Brain surgery/ stroke			Joint replacement or other implants		
Arthritis			Bad reaction to local or general anaesthetic		
Cold sores			Blood refused by the Blood Transfusion Service		
Warning Card			Treatment that required you to stay in hospital		
High or low blood pressure			HIV, AIDS, Hep A/ B/ C, vCJD (Prion Disease)		
Fainting attacks/ giddiness/ blackouts			**Women only:**		
Headaches/ migraines/ epilepsy			Are you taking the contraceptive pill		
Taken steriods in last 2 yrs			Are you pregnant / nursing mum?		

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

Do you use tobacco (cigarettes, betel quid gutkha or supari)? Quantity & frequency?

On average, how many units of alcohol do you drink in a week?

Please provide further details on any of the above medical problems and/or any medication you are currently taking:

Please turn over »

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

	Yes	No		Yes	No
Pain or discomfort in your teeth			Unpleasant taste/ odour in your mouth		
Sensitivity in your teeth			Food often stuck between teeth		
Bleeding when brushing/ flossing			Mouth ulcers/ cold sores		
Headaches/ migraines/ jaw pain			Grinding teeth/ clenching jaw		

Making the most of your smile - can we help you with any of the following?

	Yes	No		Yes	No
Colour of your teeth			Unreplaced Missing teeth		
Shape/Position of teeth			Unsightly old crowns		
Unsightly silver fillings			Uncomfortable dentures		
Cracked/ worn down teeth			Dental Anxiety		

Would you be interested in spreading the cost of treatment with payment plans and 0% Finance options?

How did you hear about us? (If referred, please state by whom)

In passing | Advert | Web | Family/ friend | Referral | Other | Please provide further details

Signature

Please sign below to certify that you have read and understood the above information and that all of your answers are accurate and up-to-date. Any incorrect information can be dangerous to your health and you must inform us of any changes.

Patient/ Parent/ Guardian | Date / / | Dentist | Date / /

Medical History Form Updates (For Follow-up Appointments)

Please sign below to certify that the information in this Medical History Form is still accurate and up-to-date. If there are any changes in your health, please provide us with details.

Patient/ Parent/ Guardian | Date / / | Please either state 'No Changes' or provide details of changes

Patient/ Parent/ Guardian | Date / / | Please either state 'No Changes' or provide details of changes

Patient/ Parent/ Guardian | Date / / | Please either state 'No Changes' or provide details of changes

Thank you for choosing Crouch Street Dental Surgery. We are proud to grow our practice through referrals - as a valued patient of our practice, please recommend us to your family, friends and colleagues.