117 Admiral House Dental Practice

Confidential Medical History Questionnaire

Welcome

Welcome to Admiral House Dental Practice. 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

Address

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
Anaemia?	☐	☐
Diabetes?	☐	☐
Epilepsy?	☐	☐
Cancer?	☐	☐
Brain surgery?	☐	☐
Arthritis?	☐	☐
Hayfever?	☐	☐
Back trouble?	☐	☐
Eczema?	☐	☐

Or any of the following:	Yes	No
Heart condition including heart attack/ heart murmur/ angina?	☐	☐
High or low blood pressure?	☐	☐
TB or chest problems including asthma/ bronchitis?	☐	☐
Rheumatic fever or Chorea/ St Vitus' Dance?	☐	☐

	Yes	No
Liver or kidney problems including hepatitis/ jaundice?	☐	☐
Excessive bleeding after cuts, bruises or tooth extraction?	☐	☐
Blood refused by the Blood Transfusion Service?	☐	☐
A joint replacement or other implant?	☐	☐
Fainting attacks/ giddiness/ blackouts?	☐	☐
Headaches/ migraines?	☐	☐
Reaction to local or general anaesthetic?	☐	☐
Treatment that required you to stay in hospital?	☐	☐
Please tick or tell your dentist if you are HIV positive	☐	☐
Do you have any close relatives with Creutzfeldt Jakob Disease?	☐	☐
Do you chew tobacco/ pan/ use gutkha or supari now (or have you in the past)?	☐	☐
Growth hormone treatment before the mid 80's?	☐	☐

Your Medical History Continued...

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?

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

Please provide details of any medication you are taking

Female Patients Only

	Yes	No		Yes	No
Are you pregnant?	☐	☐	Are you taking the contraceptive pill?	☐	☐

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 your teeth?	☐	☐
Bleeding when brushing/ flossing?	☐	☐	Mouth ulcers/ cold sores?	☐	☐

Can we help you with any of the following?

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

Stained/ discoloured teeth	☐	Missing teeth	☐
Uneven teeth/ gaps	☐	Crossed over/ crooked teeth	☐
Unsightly fillings	☐	Bad breath	☐

Signature

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

Patient	Date	Dentist	Date
	/ /		/ /

Medical history update

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

Date	No change	List any changes below	Patient's initials