



PATIENT MEDICAL AND DENTAL HISTORY

Patient Name: _____

Date of Birth: _____

Confidential Medical History

To offer the best and most appropriate dental care we ask that you provide us with as much detail as possible about your medical history.

Please complete all questions.

Name _____ Mr/Mrs/Ms/Master/Miss/Dr/Other

Address _____

_____ Post Code _____

Phone _____ Mobile _____

E-mail Address _____ Occupation _____

School (if relevant) _____

Parent/Guardian Name (if relevant) _____

Doctor's Name _____

Doctor's Address _____

How did you hear about the practice? Friend/Family Yellow Pages Internet/Website

If another please advise _____

Did any friends or family recommend you come to Bachelors Walk? _____

Are You:	Circle	Details
Receiving treatment from your doctor or hospital?	Yes/No	_____
Taking any prescribed medication?	Yes/No	_____
Carrying a medical warning card?	Yes/No	_____
Pregnant or likely to be so?	Yes/No	_____

Have you ever suffered from:	Circle	Details
Allergies to medicines (e.g. Penicillin)?	Yes/No	_____
Allergies to food/substances (e.g. Latex)?	Yes/No	_____
Had rheumatic fever or chorea?	Yes/No	_____
Asthma, bronchitis, or any other chest condition?	Yes/No	_____
Fainting, blackouts or epilepsy?	Yes/No	_____
Heart problems, blood pressure or stroke?	Yes/No	_____
Diabetes (or in the family)?	Yes/No	_____
Bone or joint disease?	Yes/No	_____
Bruising or persistent bleeding after injury tooth extraction or surgery?	Yes/No	_____
Liver disease?	Yes/No	_____
Any other serious illness or infectious disease?	Yes/No	_____
Blood refused by the blood transfusion service?	Yes/No	_____
A bad reaction to local anaesthetic?	Yes/No	_____
Treatment that required you to be in hospital?	Yes/No	_____

Alcohol: How many units per week? _____

Smoking: Do you or have you smoked in the past? _____

Please give us any other information your dentist may need to know such as self-prescribed medicines or disabilities you may have:

Patient Signature _____ Date _____

Dentist Signature _____ Date _____

Smile Evaluation

Please tick the relevant boxes to help us know your current dental concerns

	Yes	No
Do you like the way your teeth look when you smile?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any noticeable spaces between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you missing any teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your teeth to look whiter or brighter?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any old crowns that now do not match other teeth or have dark lines at the gums?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any old or stained fillings that show when you smile?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any silver fillings that you prefer were tooth coloured?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when brushing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find yourself not smiling in photos or covering you teeth with your hands or lips?	<input type="checkbox"/>	<input type="checkbox"/>
What would you most like to change about your smile?		

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