

# Medical History Form

STRICTLY CONFIDENTIAL

SURNAME: \_\_\_\_\_ FORENAMES: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ POSTCODE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ LAST DENTAL VISIT: \_\_\_\_\_

If you are not sure of any of the questions, or if your medical circumstances change, please inform the dentist.

## HAVE YOU SUFFERED FROM? (please delete as necessary)

Rheumatic Fever?	YES <input type="radio"/> NO <input type="radio"/>	Chronic Bronchitis or Asthma?	YES <input type="radio"/> NO <input type="radio"/>
Have you been treated with steroids in the past two years?	YES <input type="radio"/> NO <input type="radio"/>	Have you been tested positive for Hepatitis B, Hepatitis C, CJD or HIV?	YES <input type="radio"/> NO <input type="radio"/>
Any Heart Complaint?	YES <input type="radio"/> NO <input type="radio"/>	Excessive Bleeding after cuts, injuries or dental extractions?	YES <input type="radio"/> NO <input type="radio"/>
If 'yes' to any of the above, have you had heart surgery, or a pacemaker fitted?	YES <input type="radio"/> NO <input type="radio"/>	Have you ever had blood refused by the Blood Transfusion Service?	YES <input type="radio"/> NO <input type="radio"/>
Are you pregnant or breast-feeding?	YES <input type="radio"/> NO <input type="radio"/>	High Blood Pressure?	YES <input type="radio"/> NO <input type="radio"/>
Have you had a joint replacement operation?	YES <input type="radio"/> NO <input type="radio"/>	Do you carry a medical warning card?	YES <input type="radio"/> NO <input type="radio"/>
Epilepsy?	YES <input type="radio"/> NO <input type="radio"/>	Any other serious illnesses?	YES <input type="radio"/> NO <input type="radio"/>
Are you currently taking any medicines or tablets?	YES <input type="radio"/> NO <input type="radio"/>	Are you a smoker?	YES <input type="radio"/> NO <input type="radio"/>
Diabetes?	YES <input type="radio"/> NO <input type="radio"/>	How many per day	<input type="text"/>
Are you allergic to any medication, tablets or antibiotics?	YES <input type="radio"/> NO <input type="radio"/>	How many units of alcohol per week do you have?	<input type="text"/>

Please enter details of any 'yes' answers:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name and surgery of doctor (GP): \_\_\_\_\_

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

# New Patient Questionnaire

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PATIENT NAME:

DATE OF BIRTH

Dear Patient,

At Hockley Dental Practice we would like to take the time to understand how to treat you in the way you want. The questions below are designed to help us offer you the treatments and therapies you are interested in. Our dentists are constantly educating themselves in new techniques so we can offer you the best possible service.

## Previous Dental Experience:

Q. When was the last time you visited the dentist?

Q. Have you had any bad experience with previous treatment in the past?

YES  NO

Q. Are you nervous or anxious when visiting the dentist?

YES  NO

Q. If so would you be interested in sedation?

YES  NO

Q. Is there anything we can do to make your treatment here more comfortable?

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## Treatments for you:

Please tick if any of the treatments or services below interest you ?

- |  |   |
|--|---|
| <input type="checkbox"/> Tooth Whitening                 | <input type="checkbox"/> Snoring Treatments                 |
| <input type="checkbox"/> Implants                        | <input type="checkbox"/> Mouthguards                        |
| <input type="checkbox"/> Sedation (for nervous patients) | <input type="checkbox"/> Fine lines & Wrinkle therapies     |
| <input type="checkbox"/> Treatment for headaches         | <input type="checkbox"/> Smile Makeovers (cosmetic veneers) |
|  | <input type="checkbox"/> Replacement of worn fillings       |

Q. Are there any treatments not listed above that you would like ? (e.g. replacement denture, closing gaps etc.)

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Q. Where did you hear about us ?

Recommendation (Friends & Family)  Live locally  Advert  Website