

CONFIDENTIAL MEDICAL HISTORY

Certain medical conditions can affect your dental treatment, so please provide as much information as possible in the questionnaire below.

SURNAME Mr/Mrs/Miss _____ SEX: MALE/FEMALE

FORENAME (S) _____

ADDRESS _____

_____ POSTCODE _____

TEL NO HOME: _____ MOBILE _____ WORK _____

EMAIL ADDRESS: _____

DATE OF BIRTH _____ OCCUPATION _____

WHEN DID YOU LAST RECEIVE DENTAL TREATMENT _____

YOUR DOCTOR'S NAME & ADDRESS _____

How did you hear of dentalessence Burgess Hill? _____

	YES	NO	IF YES, PLEASE GIVE DETAILS
Are you able to manage the stairs?			
Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?			
Are you taking any medicines, tablets, drugs or injections or using any creams, ointments or inhalers?			
Are you taking or have you taken steroids in the last 2 years?			
Are you allergic to penicillin?			
Are you allergic to any medicines, foods, or materials?			
Do you carry a warning card?			
Are you pregnant or a nursing mother?			
Are you HIV positive?			
Have you ever been told you have a heart murmur, heart problem, angina or high blood pressure?			
Have you ever had your blood refused by the Blood Transfusion Service?			
Have you ever had a bad reaction to a local or general anaesthetic?			
Do you have a pacemaker or have you had heart surgery?			

Please continue on next page...

	YES	NO	
Do you suffer from hay fever, eczema or have any other allergy?			
Do you suffer from bronchitis, asthma or other chest condition?			
Do you have fainting attacks, giddiness, blackouts or epilepsy?			
Do you have diabetes or does anyone in your family?			
Do you bruise easily or suffer persistent bleeding following a tooth extraction or injury or does anyone in your family?			
Do you think there are any other aspects, concerning your health, that your dentist should know about?			
On average, how much of the following do you consume per day?	Cigarettes _____ Alcoholic Drinks _____		
Are you exempt from NHS charges?			

If you could change your smile what would you like to have done?											
How would you rate your smile from 1-10?	1	2	3	4	5	6	7	8	9	10	
1 – I'm embarrassed / 5 – it's average / 10 – it's beautiful											
If applicable, would you like to change your old black fillings?								Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Would you like to have straighter teeth?								Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Would you like to have whiter teeth?								Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Are you concerned about any gaps/missing teeth/black lines around teeth or existing crowns?								Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Please circle any of the treatments below which you may like your dentist to discuss with you in more detail.											
Implants	Veneers	Braces (Cosmetic or Fastbraces)	Veneers	Smile Makeover	Botox						

I would like NHS AND PRIVATE options or PRIVATE ONLY options

Please circle **THREE** words / phrases to highlight which aspects of your dental care are most important to you:

Cleanliness Convenience of appointments Service Friendly Staff Communication skills of your dentist

Dental Charges Latest equipment Pain free dentistry Sympathy towards my nervousness

SIGNED _____ DATE _____

Patient / Parent / Guardian (delete as applicable)