Confidential Medical History Form

Title:_____ Name:_____ Date of Birth:_____

Address:_____

Tel. No. Home:_____ Work:_____ Mobile:_____

Email Address:_____ Occupation: _____

Doctors Name and address:_____

Contact in case of Emergency: Name:_____ Tel: No: _____

Messages may be left with family member: Yes ☐ No ☐ Messages may be left on answer phone: Yes ☐ No ☐

We email patients quarterly newsletters, details of upcoming events etc. If you **do not** want to receive these communications please place and **X** in the relevant boxes: Product & Service Information or Promotion ☐ Newsletters ☐ Important Notifications ☐

Are You	Yes	No	Details
Pregnant?	☐	☐	Due Date:
Attending or receiving treatment from a doctor, hospital, clinic or specialist?	☐	☐	
Taking any prescribed or non prescribed medicines?	☐	☐	

Have You	Yes	No	Details
Had Bisphosphonates by infusion or tablets	☐	☐	
Any allergies to medicines, materials or food e.g. latex or penicillin	☐	☐	
Had Rheumatic Fever or Chorea (St. Vitus' Dance)?	☐	☐	
Had jaundice, liver, kidney disease or hepatitis?	☐	☐	
Ever been told you have a heart murmur or heart problem, angina, high Blood pressure or heart attack?	☐	☐	
Ever had a bad reaction to a local anaesthetic?	☐	☐	
Had brain surgery, surgery on a tumour or cyst on the spine, growth hormone treatment or corneal transplant	☐	☐	
Had a joint replacement or other implant?	☐	☐	
Been hospitalised? If yes for what and when?	☐	☐	

Do You	Yes	No	Details
Have arthritis?	☐	☐	
Have a pacemaker?	☐	☐	
Suffer from fainting attacks, giddiness or blackouts	☐	☐	
Suffer from epilepsy?	☐	☐	
Suffer from hay fever, eczema or cold sores?	☐	☐	
Have diabetes?	☐	☐	
Suffer from bronchitis, asthma or any other chest condition?	☐	☐	
Bruise easily or persistent bleed following injury or tooth extraction?	☐	☐	
Suffer from any infectious diseases including HIV & Hepatitis?	☐	☐	
Suffer from osteoporosis or bone tumours?	☐	☐	
Have a close relative with CJD (Creutzfeld Jakob Disease)?	☐	☐	
Carry any kind of Medical Warning Card?	☐	☐	
Smoke? If yes approximately how many per day	☐	☐	
Drink Alcohol? If yes approximately how many units per week?	☐	☐	

Please provide any additional details your dentist might need to know:

Signed By: Self / Parent / Guardian _____ **Date** _____

PTO to complete the New Patient Questionnaire

New Patient Questionnaire

Strictly Confidential

Please take a few moments to read and answer the questions below to help us understand your treatment needs.

Previous Dental Experience:

Q: When was the last time you visited the dentist? ☐

Q: Have you had any bad experiences with dental treatment in the past? Yes ☐ No ☐

Q: Are you nervous or anxious when visiting the dentist? Yes ☐ No ☐
(please give details below if you wish)

☐

Q: Would you like further information on the sedation options we offer? Yes ☐ No ☐

Your Dental Concerns:

Are you concerned about any of the following:

Q: Unsightly, discoloured, misshapen or crooked teeth? Yes ☐ No ☐
Q: Sensitivity to hot, cold or sweet food or drinks? Yes ☐ No ☐
Q: An unpleasant taste in your mouth or bad breath? Yes ☐ No ☐
Q: Bleeding gums when brushing or flossing? Yes ☐ No ☐
Q: Gaps or missing teeth? Yes ☐ No ☐
Q: Do you think you might grind your teeth? Yes ☐ No ☐

Treatments for You:

Please tick any of the treatments or services below that interest you:

Tooth Whitening	☐	New Dentures	☐
Dental Implants	☐	Cosmetic veneers or crowns	☐
Implant Retained Dentures	☐	Hygienist Appointments	☐
Treatment for Headaches/snoring	☐	Mouth guards / sports gum shields	☐
Tooth Coloured Fillings	☐	Teeth Straightening	☐

Are there any treatments not listed above that you would like to discuss?

One Last Thing:

How did you hear about the practice?

Recommendation ☐ Practice Website ☐ Advertisement ☐

Passing The Door ☐ Search Engine ☐

Any other means: please state ☐

Thank you for taking the time to complete this questionnaire