# Medical & Dental History

**Title:** ☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Other:

**First Name:** **Surname:**

**Gender:** ☐ Male ☐ Female **Date of Birth:**

**Nationality:** **Occupation:**

**Home Address (incl postcode):**

**Home Phone:** **Work Phone:**

**Mobile:** **E-mail Address:**

**Date of last Dental Examination?**

**How did you hear about us?** **Internet**

**Newspaper (please specify):**

**Magazine (please specify):**

**Walked past**

**Current patient (Name):**

**Other (please specify):**

| | *About Your Teeth* | Yes | No | Notes |
|---|---|---|---|---|
| 1 | Are you happy with your smile? | | | |
| 2 | Would you like your teeth to look whiter? | | | |
| 3 | Are your teeth sensitive? | | | |
| 4 | Have you any teeth you think are unsightly, misshapen or out of line? | | | |
| 5 | Are you concerned you have bad breathe? | | | |
| 6 | Do your gums bleed when you floss or brush? | | | |
| 7 | Are you concerned about: | | | |
| | Old crowns that do not match your other teeth or have dark lines at the gum? | | | |
| | Old or stained fillings that show when you smile? | | | |
| | Silver fillings which could be replaced by tooth coloured restorations? | | | |
| | Missing teeth you would like to replace? | | | |
| 8 | Do you clench or grind your teeth? | | | |

*Please write overleaf if you require more space!*

| | *About Your Health* | Yes | No | Notes |
|---|---|---|---|---|
| 1 | Are you receiving any treatment from a doctor, hospital or clinic? | | | |
| 2 | Are you taking any pills, tablets or medicines? If yes please list | | | |
| 3 | Are you allergic to anything? and if so to what? | | | |
| 4 | Have you had any serious illness or operations? | | | |
| 5 | Have you had any of the following: | | | |
| | Rheumatic fever? | | | |
| | Heart trouble, replacement heart valve, stroke, high blood pressure? | | | |
| | Sinus trouble? | | | |
| | Asthma? | | | |
| | Diabetes? | | | |
| | Hepatitis or HIV? | | | |
| 6 | Have you experienced abnormal bleeding associated with previous | | | |
| | tooth extractions, trauma or surgery? | | | |
| 7 | Do you smoke? How many per day? | | | |
| 8 | How many units of alcohol do you drink per week? | | | |
| 9 | Are you pregnant? If so what is the due date? | | | |
| 10 | Have you experienced any problems with previous dental treatment? | | | |

Signature: Date