



**smileessential**

creating confidence

## medical history

Surname: \_\_\_\_\_ First name: \_\_\_\_\_ Title: \_\_\_\_\_

Male  Female

Date of birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ How do you like to be addressed? \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Home tel: \_\_\_\_\_ Work tel: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Doctor's name: \_\_\_\_\_

Doctor's address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Who should we thank for recommending you to our practice?  
\_\_\_\_\_

When was your last visit to the dentist?  
\_\_\_\_\_

Do you worry about coming to the dentist? Yes  No   
If yes, please give details

### are you:

Currently receiving treatment from a doctor, hospital or clinic?    
Details

Taking any prescribed medicines? (tablets, creams, ointments, injections, or inhalers)    
Details

Taking any non-prescribed drugs? (eg Aspirin)    
Details

Allergic to any medicines (eg Penicillin), substances (eg Latex, rubber) or foods?    
Details

Carrying a medical warning card?    
Details

Pregnant? If YES please give expected delivery date

Please continue overleaf

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## have you:

Yes ✓ No

Had rheumatic fever or chorea?

Details

 

Ever had any heart problems (eg Heart murmur), angina or stroke?

Details

 

Had liver disease (eg jaundice, hepatitis) or kidney disease?

Details

 

Had any close relatives with Creutzfeldt-Jakob Disease (CJD)?

Details

 

Had any other serious illness?

Details

 

Had a joint replacement or other implant?

Details

 

Been hospitalised?

If so, what for and when?

 

Had a bad reaction to general or local anaesthetic?

Details

 

Had blood refused by the Blood Transfusion Service?

Details

 

## do you:

Have arthritis?

Details

 

Have a pacemaker, or have you had any form of heart surgery?

Details

 

Suffer from high or low blood pressure?

Details

 

Suffer from hay fever or eczema?

Details

 

Suffer from bronchitis, asthma or other chest condition?

Details

 

Have fainting attacks, giddiness, blackouts or epilepsy?

Details

 

Have diabetes or does anyone in your family?

Details

 

Bruise easily or bleed excessively following injury, tooth extraction or surgery?

Details

 

Have any infectious diseases? (including HIV and hepatitis)

Details

 

Smoke?

If so, approximately how many per week?

 

Drink alcohol?

If so, how many units per week?

 

Date:

Signed: