Goodwin & Associates

Confidential
Medical History Form

Please provide us with your general health All details contained in this questionnaire are strictly confidential and necessary to help us to treat you safely.

Details:

Name:		**D.O.B:**		**GP Practice:**	
Home phone:		**Mobile:**		**Email:**	

Are you currently:

	Yes	No
Receiving any treatment from a doctor, hospital or clinic? *(please give details)*		
Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers)? *(please give details)*		
Carrying a medical warning card? *(please give details)*		
(Women only) Pregnant?		

Details: *(Including medications)*

Do you suffer from, or have you previously suffered from: *(please give details)*

	Yes	No
A bad reaction to general or local anaesthetic?		
Allergies to any medicines (e.g. penicillin), substances (e.g. Latex/rubber) or foods?		
Cold Sores?		
Hay-fever or eczema?		
Asthmas, Bronchitis, or other chest conditions?		
Heart Problems?		
Diabetes?		
Neurological (nerve) diseases (e.g. neuropathies, MS etc.)?		
Arthritis?		
Bruising or persistent bleeding, following injury?		
Any infectious diseases (including HIV, hepatitis, CJD, TB or MRSA)?		
Kidney disease?		
Epilepsy?		
Gastric Problems?		
High/Low blood pressure?		
Any other serious illness?		

Details:

How many units of alcohol do you drink per week? Units per week ____ *(one unit is equal to a glass of wine, half pint of lager or measure of spirit).*

Do you smoke tobacco products now or have you in the past? No ☐ Yes ☐ In past ☐ Quantity ☐ per day

Smile Assessment *(optional)* **Like your smile?** On a scale of 1-10, how much do you like your smile?

1	2	3	4	5	6	7	8	9	10
Not much				It's ok					I love it

We want to meet your needs and address any concerns you may have, Please tick any of the following you feel applies to you:

My teeth are not as bright and white as I would like them to be	☐	I have a missing tooth	☐
I would like straighter teeth	☐	My dentures feel uncomfortable	☐
I don't like the colour of my fillings/the appearance of my crown(s)	☐	Some of my teeth are chipped or misshapen	☐

Any further comments:

Completed by (please tick): Self ☐ Parent ☐ Guardian ☐ Carer ☐

Signature: ____ **Date:** ____