Goodwin & Associates
Dental Practice

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 (e.g. Angina, pacemaker)?		
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 would like straighter teeth

I don't like the colour of my fillings/the appearance of my crown(s)

I have a missing tooth

My dentures feel uncomfortable

Some of my teeth are chipped or misshapen

Any further comments:

Please be aware that the weight restriction on our dental chairs is 21 stone max. For your health and safety, please advise the dentist if you feel this may apply to you, so we can make alternative arrangements.

Completed by (please tick): Self Parent Guardian Carer

Signature: **Date:**