ELGIN DENTAL CARE
◆ MAIDA VALE ◆

# Medical History Form

For your dentist to provide you with the best possible care, he/she needs an up-to-date record of your medical history. You should update and sign this form on each visit.

*All information is strictly confidential.*

## Details

Title: Forename:

Surname:

Sex: Date of Birth:

Occupation:

Address:

Postcode:

Tel (h):

Tel: (w):

Tel: (m)

email address:

Would you be interested in online booking?: Yes ☐ No ☐

The practice can contact me by Text ☐ Email ☐ Phone ☐

Emergency contact name and telephone number:

GP's name, address and telephone number:

How did you hear about us: Internet ☐ Referral ☐

Signage ☐ Other ☐ (Please specify)

Do you require translation services? Yes ☐ No ☐

If yes, what language(s)?

## Completed by

Signature

Printed Name

Date

Self ☐ Parent ☐ Guardian ☐

By signing this form you are agreeing to the following statement: "I confirm that the information provided is accurate and understand that any non-disclosure could potentially be dangerous to my treatment and that by signing this form I accept full responsibility for any adverse effects that my dentist could not have predicted without such information."

## Updates

| | | |
|---|---|---|
| Date of Review | Date of Review | Date of Review |
| Any Changes? YES ☐ NO ☐ | Any Changes? YES ☐ NO ☐ | Any Changes? YES ☐ NO ☐ |
| Changes Advised | Changes Advised | Changes Advised |
| Patient's signature | Patient's signature | Patient's signature |
| Dentist's Signature | Dentist's Signature | Dentist's Signature |

The information you supply will be used by Elgin Dental Care for the purposes of your dental care only, within the terms of the Data Protection Act 1998 and we shall not supply it to third parties. Should you have any further questions regarding the use of your personal information, please do not hesitate to ask.

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# Medical History Form

## Your Health

1. Are you Pregnant? YES ☐ NO ☐

   Expected Due Date:

2. Are you receiving any form of treatment from a doctor? YES ☐ NO ☐ If yes, please specify:

3. Are you taking any regular medication?
   YES ☐ NO ☐

   If yes, please specify:

4. Are you allergic to any medicines or materials (e.g. antibiotics, latex, local anaesthetic, etc.)?
   YES ☐ NO ☐

   If yes, please specify:

5. Do you suffer, or have you suffered from any of the following?

   ☐ Angina ☐ Cardiac defect ☐ Any other conditions

   ☐ Heart Murmur ☐ Rheumatic fever

   ☐ Heart Attack ☐ High Blood Pressure

   ☐ Diabetes ☐ Abnormal Bleeding

   ☐ Epilepsy ☐ Stroke

   ☐ Jaundice, Hepatitis ☐ Joint replacement

   ☐ Osteoporosis ☐ Asthma

   ☐ Lung Disease or breathing difficulty

6. Do you smoke or tobacco products (e.g. paan, guktha, snuff)?
   YES ☐ NO ☐ If yes, how much per day?

7. Do you drink alcohol? YES ☐ NO ☐ If yes, how many units of alcohol do you drink in a week?

   1-5 ☐ 6-10 ☐ 11-15 ☐ Over 16 ☐

   Have you taken steroids in the last two years? YES ☐ NO ☐

8. Are there any other aspects concerning your health that you think the dentist should know about?
   YES ☐ NO ☐ If yes, please specify:

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# Medical History Form

## Dental History

1. Do you suffer from mouth ulcers?
   YES ☐ NO ☐
2. Do you suffer from cold sores?
   YES ☐ NO ☐
3. Do you suffer from dry mouth?
   YES ☐ NO ☐
4. How often do you brush your teeth?
   ______________________
   ______________________
5. Do you use anything to clean between your teeth?
   YES ☐ NO ☐
6. Do your gums bleed?
   YES ☐ NO ☐ If yes, when?
   ______________________
   ______________________
   ______________________
7. Do you suffer from bad breath?
   YES ☐ NO ☐
8. Do you use a mouthwash?
   YES ☐ NO ☐ If yes, what brand and how often?
   ______________________
   ______________________
9. Is there anything that you do not like about your teeth/smile?
   ______________________
   ______________________
   ______________________
   ______________________
   ______________________
   ______________________
10. Are you a nervous dental patient?
    YES ☐ NO ☐
11. When did you last visit the dentist and what did you have done?
    ______________________
    ______________________
    ______________________
    ______________________
    ______________________
    ______________________
12. When did you last have an X-Ray (dental or otherwise)?
    ______________________
    ______________________
    ______________________

## Occlusal Screening

1. Do you clench or grind your teeth during the day?
   YES ☐ NO ☐
2. Have you ever been aware of clenching or grinding your teeth at night?
   YES ☐ NO ☐
3. Do your jaws feel tired when you wake up?
   YES ☐ NO ☐
4. Do you suffer from chronic headaches of any kind?
   YES ☐ NO ☐
5. Do you experience chronic neck or shoulder pain?
   YES ☐ NO ☐
6. Have you ever had pain in your jaw joints, sides of your face or around your ears?
   YES ☐ NO ☐
7. Have your jaws ever clicked or popped when you open your jaw?
   YES ☐ NO ☐
8. Have you ever experienced difficulty moving your jaw or opening your mouth?
   YES ☐ NO ☐
9. Do you chew on only one side of your mouth?
   YES ☐ NO ☐

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## Notes

## Communications

If I am unable to speak/receive a message/read any correspondence†, I authorise the Practice to leave a voice message on this number:

______________________

Or communicate with my husband/wife/partner/parent/carer/other†:

Give name: ______________________

Relationship: ______________________

Date: ______________________

Signed:

† Delete as applicable