SMILEWELLING
DENTAL CARE

CONFIDENTIAL MEDICAL HISTORY FORM

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All information provided by you will help us treat you safely and will be kept confidential.

Title ______ First Name ______________ Surname ______________

Sex M ☐ F ☐ Date of Birth D ☐ M ☐ Y ☐

NHS No. ______________ Mobile ______________

Tel. Home ______________ Tel. Work ______________

Occupation ______________ Email ______________

Address ______________________________

GP Name Address ______________ Postcode ______________

______________ Dr. Tel ______________

I am happy to receive communication Text/Email/Letter ☐

Patients under **16** - Parental responsibility (Both parents), ☐
If not please state who has parental responsibility ______________

DATE	UPDATE TO MEDICAL HISTORY

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Emergency contact Person ______________

Phone Number ______________ Relationship to me ______________

CURRENT CONDITIONS & ALLERGIES

	Question			
1.	Are you carrying a medical warning card?	Yes ☐	No ☐	Not sure ☐
2.	Are you receiving treatment from a doctor, hospital or clinic?	Yes ☐	No ☐	Not sure ☐
3.	Are you pregnant?	Yes ☐	No ☐	Not sure ☐
4.	Are you allergic to any medicines (e.g., Penicillin), general or local anaesthetics, substances (e.g., latex/rubber), or foods?	Yes ☐	No ☐	Not sure ☐
5.	Do you suffer from hay fever, any skin diseases or eczema?	Yes ☐	No ☐	Not sure ☐

MEDICINES & TREATMENTS

	Question			
6.	Are you taking any (self-) prescribed medicines (e.g., tablets, ointments, injections, inhalers, eyedrops, suppositories, nebulisers, the contraceptive pill or HRT)?	Yes ☐	No ☐	Not sure ☐
7.	Have you ever had a steroid treatment?	Yes ☐	No ☐	Not sure ☐

DO YOU SUFFER FROM

	Question			
8.	Any heart problems, angina, heart murmur, high blood pressure or have you ever had a stroke?	Yes ☐	No ☐	Not sure ☐
9.	Bruising or persistent bleeding following injury, surgery or tooth extraction?	Yes ☐	No ☐	Not sure ☐
10.	Bronchitis, asthma or any other chest condition?	Yes ☐	No ☐	Not sure ☐
11.	Any infectious diseases (e.g., HIV, hepatitis, TB)?	Yes ☐	No ☐	Not sure ☐
12.	Diabetes?	Yes ☐	No ☐	Not sure ☐
13.	Kidney or liver diseases (e.g., jaundice, hepatitis)?	Yes ☐	No ☐	Not sure ☐
14.	Neurological / nerve diseases (e.g., neuropathy, MS, chorea) or fainting attacks, giddiness or epilepsy?	Yes ☐	No ☐	Not sure ☐
15.	Arthritis or rheumatic fever?	Yes ☐	No ☐	Not sure ☐
16.	Muscle problems (e.g., myopathy, dystrophy, paralysis)?	Yes ☐	No ☐	Not sure ☐
17.	Stomach, ulcers, hiatus hernia, or indigestion?	Yes ☐	No ☐	Not sure ☐
18.	Any other serious illnesses?	Yes ☐	No ☐	Not sure ☐

SURGICAL & HOSPITAL STAYS

	Question			
19.	Have you ever had a heart or brain surgery?	Yes ☐	No ☐	Not sure ☐
20.	Have you had a joint replacement or any other implant?	Yes ☐	No ☐	Not sure ☐
21.	Have you ever been treated in a hospital?	Yes ☐	No ☐	Not sure ☐

FAMILY HISTORY

	Question			
22.	Does anyone in your family have diabetes?	Yes ☐	No ☐	Not sure ☐
23.	Has anyone in your family ever suffered from cancer?	Yes ☐	No ☐	Not sure ☐

DRINKING, SMOKING & CHEWING

24. How many units of alcohol do you drink per week? (1 unit = half pint of lager or one shot of spirits or a single glass of wine/aperitif — ☐ Units Per Week
25. Do you smoke or chew tobacco products now? Or did you in the past? — Yes ☐ No ☐ In Past ☐ Times Per Day ☐
26. Oral Hygiene
    How many times do you brush each day? ☐
27. What type of brush do you use? — Manual ☐ Electronic ☐
28. Do you clean interdentally with? — Floss ☐ Brushes ☐
29. How often? ______________________

Question Number	Please list any additional details to the 30 previous question (for each detail, mark the respective question number on the left)

Please list any self-prescribed medication (e.g., aspirin)	Please list any medication prescribed by your doctor
1 ______	1 ______
2 ______	2 ______
3 ______	3 ______
4 ______	4 ______
5 ______	5 ______

What is your ethnic group? Please choose one selection from this list to indicate your ethnic group

- ☐ White British
- ☐ White Irish
- ☐ Other white Background
- ☐ White & Black Caribbean
- ☐ White & Black African
- ☐ White & Asian
- ☐ Other Mixed Background
- ☐ Asian / Asian British Indian
- ☐ Asian / Asian British Pakistani
- ☐ Asian / Asian British Bangladeshi
- ☐ Other Asian Background
- ☐ Chinese
- ☐ Black / Black British Caribbean
- ☐ Black / Black British African
- ☐ Other Black Background
- ☐ Any other ethic group
- ☐ Patient Declined

VISIT YOUR DENTIST

- How do you feel when visiting a dentist? Anxious ☐ Nervous ☐ I feel relaxed ☐
- When did you last visit a dentist? Month ☐ Year ☐
- Are there any dental procedures, which have frightened you in the past, or which make you nervous?

____

- Are there any cosmetic treatments you have considered?

____

DATE	UPDATE TO MEDICAL HISTORY	DATE	UPDATE TO MEDICAL HISTORY

DECLARATION & SIGNATURE

I confirm that I have read the above and filled in this form to the best of my ability.

Completed By

Self ☐ Parent ☐

Guardian ☐ Dentist ☐

Date D ☐ M ☐ Y ☐

Signature

THANK YOU FOR YOUR TIME AND PATIENCE!

At SMILEWELLING DENTAL CARE, we are always happy to help you!
Please talk to us at **020 8854 0573** should you have any questions!

SMILEWELLING
DENTAL CARE