

THE ESSEX DENTAL CLINIC CONFIDENTIAL MEDICAL FORM

Please provide us with information about your personal details and general health to help us treat you safely. Do not answer any questions you do not understand, you will have the opportunity to discuss any queries with your dentist who will be happy to answer any of your questions. All information will be kept strictly confidential by the people caring for you!

| | |
|------------------------------|--|
| Title | |
| Patients full Name | |
| DOB | |
| Sex | |
| Address | |
| Tel.no.Home | |
| Tel.no Mobile | |
| Tel.no.Work | |
| Email Address | |
| NHS no. | |
| NI no | |
| Doctors name | |
| Doctors Address | |
| Doctors phone no. | |
| Next of Kin & contact number | |

We hope you will be very satisfied with the care you receive here. We would like to know what made you choose us.

| | |
|--------------------------|--|
| Referred by: | |
| Previous patient | |
| Recommended by a friend | |
| Convenient surgery times | |
| Family member a patient | |
| Convenient location | |
| Newspaper | |
| Flyer | |
| Website | |
| Other | |
| Last dental visit | |
| Occupation | |
| Ethnic Group | |

| ARE YOU CURRENTLY | YES | NO | IF YES PLEASE GIVE DETAILS |
|---|------------|-----------|-----------------------------------|
| Pregnant | | | |
| Receiving treatment from a hospital or doctor | | | |
| Taking any prescribed medicines/tablets/inhalers/injections | | | |
| Details of medications | | | |
| Carrying a medical warning card | | | |
| Allergic to any medicines/antibiotics | | | |
| DO YOU SUFFER FROM | YES | NO | IF YES PLEASE GIVE DETAILS |
| Allergies to substances (e.g. Latex) or food | | | |
| Hay fever | | | |
| Eczema | | | |
| Asthma | | | |
| Bronchitis or other chest conditions | | | |
| Heart problems | | | |
| High blood pressure, angina or stroke | | | |
| Fainting attacks, giddiness, epilepsy, blackout | | | |
| Muscle problems (myopathy, dystrophy, paralysis) | | | |
| Diabetes | | | |
| Neurological (nerve) diseases, (neuropathy, MS) | | | |
| Arthritis | | | |
| Bruising | | | |
| Any infectious diseases (including HIV or Hepatitis) | | | |

Please turn over

| DID YOU, AS A CHILD OR SINCE, HAVE | YES | NO | IF YES PLEASE GIVE DETAILS |
|---|------------|-----------|-----------------------------------|
| Treatment that require you to be in hospital | | | |
| Rheumatic fever, heart murmur | | | |
| Kidney or liver disease (e.g. jaundice, hepatitis) | | | |
| Osteoporosis &/or bisphosphonate treatment | | | |
| Any other serious illness | | | |
| Blood refused by the Blood Transfusion Service | | | |
| A bad reaction to general or local anaesthesia | | | |
| A joint replacement or other implants | | | |
| Heart surgery | | | |
| Brain surgery | | | |
| Growth Hormone before the mid 1980's | | | |
| A close relative with Creutzfeldt Jakob Disease | | | |
| Steroid treatment | | | |
| DRINKING | | | UNITS PER WEEK |
| How many units of alcohol do you drink per week? (A unit = ½ pint of lager, a glass of wine/aperitif, a single measure of spirit.) | | | |
| SMOKING | YES | NO | TIMES PER WEEK / DETAILS |
| Do you smoke now or did you in the past? | | | |
| Do you chew any tobacco products? (or did you in the Past?) | | | |

Today's advances in dental techniques and materials means that we are now more than ever able to help you achieve the smile you've always wanted.

| QUESTIONS | YES | NO | COMMENT |
|--|------------|-----------|--------------------------------|
| Are you satisfied with the appearance of your teeth? | | | |
| Are you self-conscious when you smile? | | | |
| Do you wish your teeth were whiter? | | | |
| Do you have any discoloured teeth or filling? | | | |
| Do you have any irregularly positioned or shaped teeth? | | | |
| So you wish your fillings at the back were tooth coloured? | | | |
| Do your gums bleed and look red & swollen? | | | |
| Do you suffer from bad breath (halitosis)? | | | |
| On a scale of 1 – 10 how happy are you with your smile? | | | Poor 1 2 3 4 5 6 7 8 9 10 good |
| Do you suffer from sleep apnoea/snoring/grinding at night? | | | |
| Do you need a mouthguard for sport? | | | |

Signature.....

Date.....

Dentist Signature.....

Date.....

