Confidential Medical History

St Oswald's Dental Surgery

Personal Details

Title (Mr, Mrs. Miss, Ms, other title)	
First Name	
Surname	
Gender ☐ Male ☐ Female	
Date of Birth	
Address	
Post Code	
Home Telephone	Work Telephone
Mobile Telephone	Email
Occupation	

Doctor Information

GP Surgery	
Address	
Post Code	

Emergency Contact

Name
Relation to you
Telephone

Dental History

Do you have dental pain or a problem at present?

Do you become anxious or uncomfortable from dental treatment?

Are you interested in the following types of dental treatment?

- ☐ Improving gum health
- ☐ Seeing the dental hygienist
- ☐ Filling spaces where teeth are missing
- ☐ Other
- ☐ Replacing silver fillings or ugly crowns
- ☐ Straighter teeth
- ☐ Whitening

Are you currently?	Yes	No	Give Details
Receiving treatment from a doctor, hospital or clinic?	☐	☐	
Carrying a medical warning card?	☐	☐	
Pregnant or possibly pregnant?	☐	☐	Due Date:
Prescribed medications? PLEASE LIST THEM ALL	☐	☐	

PLEASE TURN OVER

Have you ever had?	Yes	No	Give Details
Allergies to any medications or substances?	☐	☐	
Asthma, bronchitis, or other chest condition?	☐	☐	
Fainting attacks, giddiness, blackouts or epilepsy?	☐	☐	
Diabetes?	☐	☐	
Does anyone in your family have diabetes?	☐	☐	
Bone or joint disease, or taken medicine that affects your bones?	☐	☐	
Any infectious diseases (e.g.HIV or Hepatitis)?	☐	☐	
A bad reaction to local or general anaesthetic?	☐	☐	
Treatment that required you to be in hospital?	☐	☐	
Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐	☐	
Liver or kidney disease (e.g. jaundice or hepatitis)?	☐	☐	
High blood pressure?	☐	☐	
Heart problems, angina or stroke?	☐	☐	
Congenital heart disease, previous infective endocarditis, or prosthetic valve surgery	☐	☐	
Heart Surgery, e.g. stent or pacemaker fitment?	☐	☐	

Tobacco and Alcohol	Yes	No	In Past	Details
Do you smoke?	☐	☐	☐	_____per day, for_____years
Do you drink alcohol?	☐	☐	☐	_____units per week A unit is half a pint of lager, a single measure of spiritsor a small glass of wine.

Is there any other important information your dentist should know?

How did you hear about the practice? (New patients only)

Patient / Guardian Signature..... Date.....