the smiles studio

144 Bournemouth Road, Chandlers Ford, Hampshire – SO53 3AL

Confidential Medical History Questionnaire

Like all dentists, we ask patients for information about their general health to help us fully assess their dental health and to help us treat them safely. Please answer all the questions and then sign the form with the date of signature.

Title: Mr/ Mrs./Ms/ Miss/ Dr/ Other	**First Name:**	**Surname:**

Address:	**Contact Details: Please tick preference for reminders** Residence: ( ) Work: ( ) Mobile: ( ) Email Id:
D.O.B:	**Sex: Male / Female**
Marital Status: Single/ Married	**Occupation:**
Person to contact in case of emergency: Name: Ph. Number: Relationship:	**GP Surgery:** **Address:**
When was your last dental checkup?	**How did you hear about us?** **(Leaflet/recommended/passing/adverts/internet/etc.)**
Do you need to be seen in the downstairs surgery? Yes / No	

Please answer the following as accurately as you can. We need to know the answers to all of these questions as there are many medical conditions and medicines that can affect your dental health and we wish to assess your dental health as accurately as possible each time we see you.

Are you:	Yes	No	Details:
1) Receiving any medical treatment from a doctor / hospital?			
2) Taking any medicines from your doctor? If Yes which ones (please bring a repeat prescription or list on the back if more space is needed).			
3) Taking or have taken steroids in the last two years?			
4) Allergic to or have had a reaction to anything ever in the past?			
5) Wearing any Removable Dental Appliances?			
6) WOMEN - Are you **Pregnant/**taking **Birth Control Pills/Nursing**			
7) Carrying a Medical Warning Card/ Bracelet?			

Do you have or have you had any of the following diseases or problems? Please tick as appropriate and give details of any conditions in the space below.

1. Damaged Valves / Artificial Heart Valves; Heart Murmur or Rheumatic Heart Disease?	**Y / N**	2. Cardiovascular Disease (Heart Trouble, Heart Attack, Angina, High Blood Pressure, Stroke) ?	**Y / N**
3. Inborn Heart Defects or Pacemaker?	**Y / N**	4. Diabetes?	**Y / N**
5. Fainting Spells or Seizures?	**Y / N**	6. Persistent Diarrhea or Weight Loss?	**Y / N**
7. AIDS or HIV Infection?	**Y / N**	8. Hepatitis, Jaundice or Liver Disease?	**Y / N**
9. Asthma or Hay Fever?	**Y / N**	10. On Warfarin or any Blood Thinners?	**Y / N**
11. Sinus Trouble?	**Y / N**	12. Thyroid Problems?	**Y / N**
13. Respiratory Problems - Emphysema etc.	**Y / N**	14. Arthritis or painful Swollen Joints?	**Y / N**
15. Stomach Ulcer or Hyperacidity?	**Y / N**	16. Hiatus Hernia?	**Y / N**
17. Kidney Trouble?	**Y / N**	18. Tuberculosis?	**Y / N**
19. Persistent Cough or Cough that produces Blood?	**Y / N**	20. Sexually Transmitted Diseases?	**Y / N**

21. Epilepsy or other neurological disease?	Y / N	22. Problems with Mental Health?	Y / N
23. Cancer?	Y / N	24. Problems of the Immune System?	Y / N
25. Had Abnormal Bleeding/ Have you required a Blood Transfusion?	Y / N	26. Blood Disorders like Anemia?	Y / N
27. Ever had any treatment for a tumor or growth?	Y / N	28. Any Serious trouble associated with any previous dental treatment?	Y / N

Please give details here ……………………………………………………………………………………………….
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Please tell us about the following specific risk factors for mouth damage:

1. Do you or did you smoke? If so how many per day …..
2. Do you or did you consume tobacco in any other form. Please specify ……
3. How many units of alcohol do you drink in the average week (1 glass of Wine, 1 spirit measure or ½ pint beer = 1 unit) …..
4. Have you had a specific stressful event recently (such as bereavement, marriage, divorce, new job, lost job, new house etc) …..

Especially if you are a new patient to the practice, please tell us a little about your thoughts regarding dental care and a few other possibly relevant matters:

1 Do you feel dentally healthy at the moment? …………………….
2 Do you have a dental concern or problem? …………………….
3 Please tell us how often you brush your teeth …………………….
4 And how often you clean *between* teeth with floss, dental sticks or interdental brushes …………………….
5 Do you use fluoride supplements such as fluoride mouth rinses …………………….
6 Do you take fizzy/sugary drinks or fruit juice frequently? …………………….
7 Is there any part of dentistry which worries you? …………………….
8 On a scale of 1 to 10, please rate your smile? (10-very good) …………………….
9 Is there anything about your smile (teeth colour/ shape/ gaps/ gums that you would like to change? …………………….

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the enquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:………………………………………………. **Date………/………/………**

Completed by Self/Guardian/Parent …………………………………………..

Changes since last exam:……………………………… …………………………………………………………………… Signature:……………………… Date: …………………	Changes since last exam:……………………………… …………………………………………………………………… Signature:……………………… Date: …………………