ELGIN
DENTAL CARE
AND IMPLANT CLINIC

committed to excellence

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 (home) Tel (work)

Tel (mob) Email

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."

YOUR HEALTH

1 Are you pregnant? Yes ☐ No ☐ If Yes, expected due date

2 Are you taking any form of treatment/ regular medication from a doctor? Yes ☐ No ☐

If Yes, please specify

3 Have you taken steroids in the last 2 years? Yes ☐ No ☐

If Yes, please specify

4 Are you allergic to any medicines/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 ☐ Heart Murmur ☐ Heart Attack ☐ Diabetes ☐ Epilepsy ☐ Jaundice, Hepatitis

☐ Osteoporosis ☐ Lung Disease or breathing difficulty ☐ Cardiac Defect ☐ Rheumatic Fever

☐ High Blood Pressure ☐ Abnormal Bleeding ☐ Stroke ☐ Joint Replacement ☐ Asthma

Any other conditions?

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 one week? 1-5 ☐ 6-10 ☐ 11-15 ☐ Over 16 ☐

8 Are there any other aspects concerning your health that you think the dentist should know about?

Yes ☐ No ☐ If Yes, please specify

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?

DENTAL HISTORY (CONTINUED)

7 Do you suffer from bad breath? Yes ☐ No ☐

8 Do you use 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 ☐

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

COMMUNICATIONS

I personally authorise the Practice to leave a voice message on this number in my absence:

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

Give name:

Relationship:

Date:

Signed:

Print name:

† Please delete as applicable

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.