ALTON DENTAL
DENTAL CENTRE & IMPLANT CLINIC
www.altondental.co.uk

Confidential Medical History Form

Title..... Surname.....

Forenames..... Male/Female.....

Address.....
.....
.....Postcode.....

Telephone Number:

Day..... Evening.....

Email Address..... Occupation.....

Date of Birth.....

Name and Address of Doctor
.....
.....Phone No.of Doctor.....

How did you hear about us?.....

Are you exempt from NHS charges? Yes ..... No.....

If so, why?.....

Which treatment do you wish to have?

NHS		Private		Mixture of both	
Yes	No	Yes	No	Yes	No

ARE YOU CURRENTLY	**YES**	**NO**	**Details**
Pregnant?	.....	.....	.....
Receiving treatment from a Doctor, hospital or clinic?	.....	.....	.....
Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?	.....	.....	....
Carrying a medical warning card?	.....	.....	.....
DO YOU SUFFER FROM			
Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?	.....	.....	.....
Reaction to local/general anaesthetic?	.....	.....	.....
Hayfever or eczema?	.....	.....	.....
Bronchitis, asthma or other chest conditions?	.....	.....	.....
Fainting attacks, giddiness, blackouts epilepsy?	.....	.....	.....
Heart problems, angina, high blood pressure or stroke?	.....	.....	.....
Diabetes (or anyone in the family)?	.....	.....	.....
Arthritis?	.....	.....	.....
Bruising/persistent bleeding following injury, tooth extraction or surgery?	.....	.....	.....
Any infectious diseases (including HIV and hepatitis)?	.....	.....	....

DID YOU, AS A CHILD OR SINCE, HAVE

	YES	NO	Details
Blood refused by Blood Transfusion?	.....	.....	.....
A joint replacement or other implant?	.....	.....	.....
Treatment that required you to be in hospital?	.....	.....	.....
Heart Surgery?	.....	.....	.....
Brain Surgery?	.....	.....	.....
Growth hormone treatment before the mid 1980s?	.....	.....	....
A close relative with CJD?	.....	.....	.....

DRINKING

Units Per week: .....
1 Unit = half a pint of lager, single spirit, or a single glass of wine

SMOKING AND CHEWING

Do you smoke any tobacco Products now (or did you in the past)? Yes No In past ..... times/day

Do you chew tobacco, pan, usegutkha Or supari now (or did you in the past)? Yes No In past .....times/day

Please Give Any Other Details Which Your Dentist Might Need to Know About?

.....
.....
.....
.....

Signature..... Date.....

Dental History

Previous Dentist.....

Why have you changed dentist? .....

How often did you attend?..... ..... **Last Visit**.....

Do your gums bleed? Yes No

Do you sometimes suffer from bad breath? Yes No

Have you any blackened silver/mercury fillings that you don't like? Yes No

Do you have any missing teeth? Yes No

Do you have any headaches, jaw aches or migraines? Yes No

If so, how often? .....

Treatment Choices: Are you interested in any of the following treatments?

White fillings Yes No

Tooth Whitening Yes No

Veneers Yes No

Crowns Yes No

Implants Yes No

Smile Analysis

On a scale of 1-10, how happy are you with your smile?

1 being least.....

Are you in any Private Insurance Scheme or Hospital Scheme which allow full/part refund of your dental charges? Yes No