

# MEDICAL HISTORY FORM



## YOUR HEALTH

1. Are you pregnant?.....YES (expected due date : )..... NO
2. Are you receiving any form of treatment from a doctor, specialist, hospital or clinic?..... YES NO
3. Are you taking any prescribed medication?(Such as tablets, creams, inhalers, injections, contraceptives, etc.)  
YES.....NO
4. Are you allergic to any medicines or materials?..... YES NO
5. Do you carry a warning card?.....YES NO
6. Do you have angina or high/low blood pressure? .....YES NO
7. Do you have bronchitis, asthma or any other chest condition?.....YES NO
8. Have you ever been diagnosed with heart disease, atheroma, valve replacement and been
9. advised to receive treatment for your gums?.....YES NO
10. Do you have hay fever, eczema or any other allergy?..... YES NO
11. Do you have fainting attacks, giddiness, blackouts or epilepsy?..... YES NO
12. Do you or anyone in your immediate family have diabetes?.....YES NO
13. Do you bruise easily or bleed excessively? .....YES NO
14. Do you smoke or use tobacco products (such as paan or guktha)?..... YES NO
15. Have you ever used tobacco products in the past?..... YES NO
16. If yes, how much?.....
17. How many units of alcohol do you drink in a week? ( A unit is a half pint measure of lager/a single measure of spirits or a glass of wine )      1 - 5 \*                      5 - 10 \*                      11 - 15\*                      over 16\*
18. Have you ever had rheumatic fever?..... YES NO
19. Have you ever had a heart attack?..... YES NO
20. Have you ever had heart surgery or a pacemaker fitted?.....YES NO
21. Have you ever had a stroke?.....YES NO
22. Have you ever had jaundice, liver, kidney disease or hepatitis?.....YES NO
23. Have you ever had a joint replacement or other implant?..... YES NO
24. Have you ever had a bad reaction to general or local anaesthetic?.....YES NO
25. Have you taken steroids in the last two years?..... YES NO
26. Are there any other aspects concerning your health that you think the dentist should know about?  
.....
27. Have you ever been exposed to the HIV virus or CJD disease?..... YES NO

## DENTAL HISTORY

1. Do you suffer from mouth ulcers? .....YES NO
2. Do you suffer from cold sores?.....YES NO
3. Do you regularly suffer from dry mouth?..... YES NO
4. How often do you brush your teeth? .....
5. Do you use anything to clean in-between your teeth? If the answer is yes, what?  
.....
6. Do your gums bleed?.....YES NO
7. Do you suffer from bad breath?.....YES NO
8. Do you use a mouthwash?.....YES NO
9. Are you aware if you grind your teeth?..... YES NO
10. How would you rate your level of stress?                      Low                      Medium                      High
11. Do you suffer from clicking jaw joints?..... YES NO
12. Do you suffer from headaches or facial pain?..... YES NO
13. Are you happy with the appearance of your teeth?..... YES NO
14. Are you happy with the colour of your teeth?..... YES NO
15. Do you currently have any broken teeth or fillings?..... YES NO
16. Do you have any areas where food gets caught?..... YES NO
17. Do your teeth feel tender when you bite or chew?..... YES NO
18. Do you have or have you had any swelling or pus around the teeth?..... YES NO
19. Do you feel pain when eating or drinking cold, hot or sweet food/drink?..... YES NO
20. Has a dentist ever diagnosed you with periodontal disease, gingivitis or 'gum problems'?..... YES NO
21. Have you ever had any pain, tenderness or swelling associated with your wisdom teeth?..... YES NO
22. How do you feel about having dental treatment?.....
23. When did you last attend the dentist and what did you have done?.....
24. When was your last hygiene visit?.....
25. When did you last have X-rays taken?.....

Signature.....

Date.....