St John's Dental Practice

Advanced Dental Care

Confidential *Personal & Medical History*

So that we may offer you the best are safest care, please take a few minutes to complete this form. If you are uncertain please discuss the matter with your dentist.

Personal Details:

Title: _____ First Name:_____ Surname: _____

Home Address:_____

_____ Postcode: _____

Date of Birth: _____ Occupation: _____

Contact Number(s) : _____

Email: _____

GP Details: _____

How did you hear about us? _____

Medical History:

Have you ever had any of the following? If so, please tick as appropriate.

- ☐ Rheumatic Fever
- ☐ Chorea St Vitus Dance
- ☐ Angina
- ☐ Heart Surgery
- ☐ Previous Heart Attack
- ☐ Blood Pressure Problems
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ Replacement Heart Valve
- ☐ Asthma
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Family History of Diabetes
- ☐ Jaundice
- ☐ Hepatitis (please specify A,B,C)
- ☐ Bleeding Problems
- ☐ Family History of Bleeding
- ☐ Allergies (e.g. Penicillin/Latex)
- ☐ Prone to Fits/Blackouts/Faints
- ☐ Sickle Cell Trait or Disease
- ☐ Family History of Sickle Cell
- ☐ HIV positive (or at risk to HIV exposure)

Women only: do you know or suspect that you could be pregnant? If so, expected date of delivery? _____

Do you smoke? If yes, average daily use? _____

Are you taking any medications? (Injections/pills/tablets/drugs/inhalers/ointments)

If yes, please specify: _____

_____

Are you undergoing any blood tests or other investigations? If yes, please specify:

_____

_____

Are you currently/have recently been under the care of your doctor?

If yes, please specify: _____

_____

Prolonged Illness? If yes, please specify: _____

_____

Name of Last Dentist: _____

Last Dental Visit: _____

Do you have dental pain/dental problems at present? _____

_____

Do you feel you have problems with your gums? _____

_____

Have you ever had any facial aesthetic treatment? Y/N _____

Would you be interested in a free consultation? Y/N _____

Signed (Patient/Parent/Guardian): _____ ***Date*** _____

Signature of Examination Clinician: _____