

New Patient Dental History

Barley Mow **Dental Care**

Title: Mr / Mrs / Miss / Ms / _____

Date of birth: _____

Name: _____

Address: _____

_____ Postcode: _____

Phone: Home: _____

Work: _____

Email: _____

Mobile _____

| |
|--------------------------|
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |

Our practice policy is to confirm all appointments 72-24 hours beforehand.
This can be via phone, email or text messaging.
Please tick the means of communication you would prefer.

Occupation: _____

How did you hear about us? Word of Mouth / Walked Past Door/
Yellow Pages / Yell.com / Website / Google / WB Advertiser / Dentons / Malmesbury Connections

If Word of Mouth who mentioned us to you? : _____

Or is another member of your household a patient or ex-patient? _____

This part of the questionnaire is to help your new dentist quickly grasp why you have come to see us for the first time. If any of it is too difficult or complex to summarise then please put a note on it saying 'discuss' and we will...

When did you last visit the dentist? _____

How often did you usually visit your dentist? _____ Or hygienist? _____

Are you having any problems or concerns with your teeth at present?

Are you concerned about the appearance or colour of your teeth?

Are there any particular aspects of dental treatment that concern you?

Medical details are covered on the reverse of this sheet.
If several family members are filling out the form only one full copy of the address is required.

Confidential Medical History for New Patients

GP:

And /or GP Surgery:

Or Malmesbury PC/Gable House

* Please list any medications you are on and give any other details which your dentist might need to know about, such as self-prescribed medicines (eg aspirin), or diffuse conditions not covered by any question , in the space at the bottom of the page below.

Are you currently

Pregnant? If so when are you due?

Receiving treatment from a doctor, hospital or clinic?

Taking any prescribed medicines (eg tablets, ointments, injections or inhalers) including contraceptives and HRT? List them in the box below please.

| Yes | No |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Did you, as a child or since, ever have:

Liver or kidney disease ?

Heart surgery?

A bad reaction to local or general anaesthetic?

Any other serious illness or medical condition?

| Yes | No |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

In a typical week how many drinks of alcohol do you have?

If you have stopped or cut back drinking alcohol also tick how many drinks you used to have.

I do not drink alcohol

Less than 10 drinks per week

10-20 drinks per week

20-30 drinks per week

More than 30 drinks per week

| |
|--------------------------|
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |

Do you suffer from (underline or give details below)

Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?

Bronchitis, asthma or other chest condition?

Fainting attacks, giddiness, blackouts or epilepsy?

Heart problems, angina, blood pressure problems or stroke?

Diabetes

Bruising or persistent bleeding following injury, tooth extraction or surgery?

Any infectious diseases (including HIV and hepatitis)?

Osteoporosis and have you ever taken bisphosphonates for it?

| Yes | No |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Do you smoke or use tobacco?

No, I have never smoked

I used to smoke. How long ago? How many?

I smoke 1-9 cigarettes a day

I smoke 10-19 cigarettes a day

I smoke 20 or more cigarettes a day

| |
|--------------------------|
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |

Details:

Signature

Date

Checked by dentist: