Do you have any of the following :-	yes	no
Loose or moving teeth?	O	O
Do you clench or grind your teeth?	O	O
Do your jaws ever feel tired, click or pop?	O	O
Do you ever have headache or earache?	O	O
Do you ever have neck or backache?	O	O
Have you ever had your teeth straightened?	O	O

If yes, give details ……...

Have you ever had any teeth removed?	O	O
Have you ever had an unpleasant dental experience?	O	O

If yes, give details ……...

Please give any other details which your dentist might need to know about (e.g. any illness, medication or concerns regarding treatment).

_____

_____

Medical History Update

Please check that the information on this form is still correct. If not, amend as necessary or note any changes below.

Date	No Change	Changes	Signature

Do you wish to discuss anything in private with the dentist ? _____

Completed by :- self / parent / guardian

Patient's signature _____ date _____

Park Road Dental Centre, 35 Park Road, Teddington, Middlesex, TW11 0AB
T: 020 8977 9229 W: parkroaddental.co.uk E: reception@parkroaddental.co.uk

Confidential Medical and Dental History Form

PARK ROAD DENTAL CENTRE

We ask you for information about your general health to help us treat you safely. All information will be kept strictly private and confidential.

Date _____

Surname _____

First Name/s _____ Title _____

Sex - Male / Female (please circle) Date of Birth _____

Address _____

_____

_____Postcode _____

Please note that we send appointment reminders by text or e-mail, please circle your preference below.

Telephone - Home _____

Mobile _____

Work _____

E-mail _____

By signing this form you are allowing us to use your email address to send you relevant information from time to time about the Practice and our services, as well as for the purposes of making referrals. If you do not wish your email details to be used in this way please tick the following box [ ]

Occupation _____ Do you have dental insurance ?_____

Marital status _____ Country of origin _____

Doctor's name and address _____

_____

Doctor's telephone number_____

Where did you hear about us? _____

Other family members at this practice _____

Are you Currently :-

	yes	no	Give details
Receiving treatment from a doctor, hospital or clinic?	O	O	…… ……...
Taking any prescribed medicines (eg tablets, ointments, injections and inhalers?	O	O	…… …… ……...
Carrying a medical warning card?	O	O	……
Pregnant or possibly pregnant?	O	O	……
Taking oral contraceptives or HRT?	O	O	……

Have you ever suffered from :-

	yes	no	Give details
Allergies to medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods?	O	O	……
Bronchitis, asthma or other chest condition?	O	O	……
Fainting attacks, dizziness, blackouts, epilepsy/seizures?	O	O	……
Heart problems, angina, blood pressure problems, stroke or heart surgery?	O	O	……
Diabetes (or does anyone in your family)?	O	O	……
Bone or joint disease?	O	O	……
Bruising or persistent bleeding following injury, tooth extraction or surgery?	O	O	……
Liver disease (e.g. jaundice , hepatitis) or kidney disease?	O	O	……
Gastric problems including reflux?	O	O	……
Depression or other mental illness?	O	O	……
Any other serious illness or infectious disease?	O	O	……
Blood refused by the Blood Transfusion Service?	O	O	……..…
A bad reaction to general or local anaesthetic?	O	O	……
Have you been hospitalised during the last 2 years?	O	O	……...…

Alcohol

How many units of alcohol do you drink per week? ……...units per week

Tobacco Use

Do you smoke any tobacco products now (or did you in the past)? yes / no / in past (please circle)
…… times per day

Dental History

When was your last dental visit? _____

How often do you go? _____

Do you have any of the following :-

	yes	no
Tooth pain / worries?	O	O
Would you prefer not to have mercury in your mouth?	O	O
Concerns with the appearance of your teeth / smile ?	O	O
If yes, give details :- ……...……		
Do you suffer from sensitivity in your teeth?	O	O
Gum problems such as :-	O	O
Tenderness?	O	O
Bleeding?	O	O
Feeling swollen?	O	O
Do you have any areas in your teeth that trap food?	O	O