

Medical History Form

Please complete in block capitals. It takes about five minutes. Ask at reception if anything is unclear — we are happy to help.

Why we ask. Some medical conditions and medicines change how we plan your treatment, which anaesthetic we use, or whether we need to speak to your doctor first. Everything you write here is confidential and stored securely under UK GDPR.

1 Your details

TITLE & FIRST NAME	SURNAME
DATE OF BIRTH (DD / MM / YYYY)	MOBILE NUMBER
HOME ADDRESS	
POSTCODE	EMAIL ADDRESS
EMERGENCY CONTACT — NAME	EMERGENCY CONTACT — NUMBER

2 Your GP

DOCTOR'S NAME	GP SURGERY
SURGERY ADDRESS	
SURGERY TELEPHONE	NHS NUMBER (IF KNOWN)

3 Medical conditions

Tick **Yes** or **No** for every line. Do you have, or have you ever had:

Heart problems angina, heart attack, heart failure	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Heart murmur, valve problem or rheumatic fever	☐ Yes	☐ No
Pacemaker or other implanted device	☐ Yes	☐ No
Stroke or mini-stroke (TIA)	☐ Yes	☐ No
Diabetes type 1 or type 2	☐ Yes	☐ No
Asthma, COPD or other breathing problems	☐ Yes	☐ No

6 Your dental history

WHEN WAS YOUR LAST DENTAL VISIT?

WHAT WOULD YOU LIKE HELP WITH TODAY?

Bleeding gums when you brush	☐ Yes	☐ No
Sensitive teeth to hot, cold or sweet things	☐ Yes	☐ No
Jaw pain, clicking or teeth grinding	☐ Yes	☐ No
Dry mouth or bad breath	☐ Yes	☐ No
Any problems with previous dental treatment or anaesthetic	☐ Yes	☐ No

HOW DO YOU FEEL ABOUT DENTAL VISITS? (CIRCLE ONE)

ANYTHING THAT WOULD MAKE YOUR VISIT EASIER

1 Relaxed · 2 · 3 A little nervous · 4 · 5 Very anxious

7 Declaration & signature

The information I have given is correct to the best of my knowledge. I will tell the practice if my health or medication changes. I understand my details will be stored securely and used only for my dental care.

SIGNATURE (PARENT / GUARDIAN IF UNDER 16)

DATE

Office use — reviewed by:	Date:	Next review due:
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