Bluebell
dental practice
www.bluebelldp.co.uk

MEDICAL HISTORY FORM

Surgery Use Only	
Dentist:	Ref:

Chigwell Practice: 020 8500 6789   Stratford Practice: 020 8555 1144

Please take a few minutes to complete this "Medical History Form" in clear BLOCK CAPITAL LETTERS, which would help us to assist you effectively.

SECTION 1

Surname: Mr / Mrs / Miss / Master / Ms / Dr ______

Forename/s: ______

Date of Birth: ______ Permanent Address: ______

______ Postcode: ______

Home Telephone: ______ Work Telephone: ______

Mobile Phone: ______ E-mail Address: ______

Occupation: ______ Appointment reminder by email or text **YES** ☐ **NO** ☐

Date of last dental treatment (if known, your previous dental practice) ______

Doctor's Name & Address (GP) ______

Post Code ______ Telephone ______

Where did you hear about us: Family & Friends ☐ Leaflet ☐ Yellow Pages ☐ Outside Sign ☐ Web ☐ Other ☐

If other, please describe: ______

SECTION 2

ARE YOU CURRENTLY:	YES	NO	IF YES, PLEASE GIVE DETAILS
Pregnant?	☐	☐	
Receiving treatment from a doctor, hospital or clinic?	☐	☐	
Taking any prescribed medicines (eg tablets, ointments, injections, inhalers including contraceptives or hormone replacement therapy)?	☐	☐	
Carrying a warning card?	☐	☐	
Taking or taken steroids in the last two years?	☐	☐	

SECTION 3

DO YOU SUFFER FROM:	YES	NO	IF YES, PLEASE GIVE DETAILS
Allergies to any medicines (antibiotics, ie penicillin, substances: latex, rubber, metals)?	☐	☐	
Hay fever, eczema or asthma?	☐	☐	
Fainting attacks, giddiness, blackouts or epilepsy?	☐	☐	
Have diabetes, or does anyone in your family?	☐	☐	
Arthritis?	☐	☐	
Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐	☐	
Any infectious disease (including HIV or hepatitis)?	☐	☐	

SECTION 4

DID YOU, AS A CHILD OR SINCE, HAVE	YES	NO	IF YES, PLEASE GIVE DETAILS
Rheumatic fever or chorea (St Vitus Dance)?	☐	☐	
Liver disease (eg jaundice, hepatitis) or kidney disease?	☐	☐	
Any other serious illness?	☐	☐	

SECTION 5

DID YOU, AS A CHILD OR SINCE, HAVE

Question	YES	NO	IF YES, PLEASE GIVE DETAILS
Blood refused by the Blood transfusion Service?	☐	☐	
A bad reaction to general or local anaesthetic?	☐	☐	
A joint replacement or other implant?	☐	☐	
Treatment that required you to be in hospital?	☐	☐	
Ever been told you have a heart murmur or heart problem, angina, blood pressure problem or heart attack?	☐	☐	
Brain surgery?	☐	☐	
Growth hormone treatment before the mid 1980s?	☐	☐	
A close relative (parents, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease?	☐	☐	

SECTION 6

DENTAL HYGIENE

Question	YES	NO	GIVE DETAILS
Do you drink alcohol? How many units of alcohol do you drink per week? (A unit is half a pint of larger, a single measure of spirits or a single glass of wine/aperitif)	☐	☐	
Do you smoke any tobacco products now or did you in the past?	☐	☐	
Do you chew tobacco, pan or supari now or did you in the past?	☐	☐	
Do you consume large amounts of acidic food or drinks	☐	☐	
Do you consume large amounts of sugary food or drinks	☐	☐	
Do your gums bleed when you brush your teeth? Do you floss or interdental brushes to clean?	☐	☐	
Do you use an electrical toothbrush?	☐	☐	

SECTION 7

COSMETIC/FACIAL ENHANCEMENT

Question	YES	NO
Like to improve the look of your smile?	☐	☐
Like to have whiter teeth, or stains removed?	☐	☐
Invisible tooth straightening for adults and teenagers? (www.invisialign.com)	☐	☐
Facial enhancement such as wrinkle and frown line reduction and lip enhancement (Botox)	☐	☐
Are you concerned with crooked or crowded teeth?	☐	☐
Do you get food trapped between your teeth?	☐	☐
Do you have concerns about your breath?	☐	☐
Private GP services?	☐	☐

SECTION 8

PLEASE GIVE ANY OTHER DETAILS WHICH YOUR DENTIST MIGHT NEED TO KNOW ABOUT, SUCH AS SELF-PRESCRIBED MEDICINES OR ANY OTHER CONDITIONS WHICH MAY HELP US? (EG. ASPIRIN)

SECTION 9

I understand and agree to the following:

- That, under my treatment plan, my treatment will have been paid for in total on completion of treatment.
- That, under my treatment plan, I may be required to pay in advance for certain items of treatment.
- That, I may be charged a fee for an appointment missed or cancelled without 24 hours prior notice.

Completed by: SELF / PARENT / GUARDIAN

Signature: ______________________ Date: ______________

SECTION 10

MEDICAL HISTORY UPDATE: Have there been any changes in your health, medicines, injections or tablets since your last course of treatment? (If you have too many changes please ask for a new form)

Signature:	Signature:	Signature:	Signature:
Date:	Date:	Date:	Date:

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