Medical History Form

STRICTLY CONFIDENTIAL

HDS
HOCKLEY DENTAL SURGERY

SURNAME: FORENAMES: DATE OF BIRTH:

ADDRESS: POSTCODE:

OCCUPATION: LAST DENTAL VISIT:

If you are not sure of any of the questions, or if your medical circumstances change, please inform the dentist.

HAVE YOU SUFFERED FROM? (please delete as necessary)

Rheumatic Fever? YES ◯ NO ◯

Have you been treated with steroids in the past two years? YES ◯ NO ◯

Any Heart Complaint? YES ◯ NO ◯

If '**yes**' to any of the above, have you had heart surgery, or a pacemaker fitted? YES ◯ NO ◯

Are you pregnant or breast-feeding? YES ◯ NO ◯

Have you had a joint replacement operation? YES ◯ NO ◯

Epilepsy? YES ◯ NO ◯

Are you currently taking any medicines or tablets? YES ◯ NO ◯

Diabetes? YES ◯ NO ◯

Are you allergic to any medication, tablets or antibiotics? YES ◯ NO ◯

Chronic Bronchitis or Asthma? YES ◯ NO ◯

Have you been tested positive for Hepatitis B, Hepatitis C, CJD or HIV? YES ◯ NO ◯

Excessive Bleeding after cuts, injuries or dental extractions? YES ◯ NO ◯

Have you ever had blood refused by the Blood Transfusion Service? YES ◯ NO ◯

High Blood Pressure? YES ◯ NO ◯

Do you carry a medical warning card? YES ◯ NO ◯

Any other serious illnesses? YES ◯ NO ◯

Are you a smoker? YES ◯ NO ◯

How many per day

How many units of alcohol per week do you have?

Please enter details of any **'yes'** answers:

Name and surgery of doctor (GP):

Signature: Today's Date:

New Patient Questionnaire

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HOCKLEY DENTAL SURGERY

PATIENT NAME: DATE OF BIRTH

Dear Patient,

At Hockley Dental Practice we would like to take the time to understand how to treat you in the way you want. The questions below are designed to help us offer you the treatments and therapies you are interested in. Our dentists are constantly educating themselves in new techniques so we can offer you the best possible service.

Previous Dental Experience:

Q. When was the last time you visited the dentist?

Q. Have you had any bad experience with previous treatment in the past? YES ◯ NO ◯

Q. Are you nervous or anxious when visiting the dentist? YES ◯ NO ◯

Q. If so would you be interested in sedation? YES ◯ NO ◯

Q. Is there anything we can do to make your treatment here more comfortable?

Treatments for you:

Please tick if any of the treatments or services below interest you ?

- Tooth Whitening ◯
- Implants ◯
- Sedation (for nervous patients) ◯
- Treatment for headaches ◯
- Snoring Treatments ◯
- Mouthguards ◯
- Fine lines & Wrinkle therapies ◯
- Smile Makeovers (cosmetic veneers) ◯
- Replacement of worn fillings ◯

Q. Are there any treatments not listed above that you would like ? (e.g. replacement denture, closing gaps etc.)

Q. Where did you hear about us ?

Recommendation (Friends & Family) ◯ Live locally ◯ Advert ◯ Website ◯