

## CONFIDENTIAL MEDICAL HISTORY FORM

- We believe in a holistic approach to treating you.
  - Could you please take time to complete the following information.
- Tick correct box.

1. Title (Dr/Mr/Mrs/Miss/Ms)
2. Surname:
3. First name:
4. How did you hear about us?
5. Date of birth: / /
6. Address:
- Postcode:
7. Work tel. No:
8. Home tel. No:
9. Mobile tel. No:
10. Email details:
11. Emergency contact no:
12. Occupation:
13. Last dental visit?
14. Your Doctor (GP)  
Name:  
Address:  
Tel No

### YOUR HEALTH

1. Are you pregnant? Yes  No   
Expected due date: / /
2. Are you receiving any form of treatment from a doctor, specialist, hospital or clinic? Yes  No   
If yes please give details:
3. Are you taking any prescribed medication? (Such as tablets, creams, inhalers, injections, contraceptives or HRT) Yes  No   
4. Are you allergic to any medicines or materials? Yes  No   
If "yes", do you carry a warning card? Yes  No
5. Do you have angina or high/low blood pressure? Yes  No

6. Do you have bronchitis, asthma or any other chest condition? Yes  No
7. Do you have hay fever, eczema or any other allergy? Yes  No   
If "yes" please give details
8. Do you have fainting attacks, giddiness, blackouts or epilepsy? Yes  No   
If "yes" please give details
9. Do you or anyone in your immediate family have diabetes? Yes  No   
If "yes" please give details
10. Do you bruise easily or bleed excessively? Yes  No
11. Are you receiving any complementary therapy? Yes  No   
If "yes" which one and why?

12. Do you smoke or use tobacco products (such as paan or guktha) Yes  No   
If "yes" how many a day
  13. Have you ever used tobacco products in the past? Yes  No
- ### YOUR HEALTH HISTORY
1. Have you ever had rheumatic fever or chorea (St. Vitus Dance)? Yes  No
  2. Have you ever had a heart attack? Yes  No
  3. Have you ever had heart surgery or a pacemaker fitted? Yes  No
  4. Have you ever had a stroke? Yes  No
  5. Have you ever had jaundice, liver, kidney disease or hepatitis? Yes  No

HOLISTIC DENTAL CARE



# RAVENSCOURT

5 RAVENSCOURT AVENUE • HAMMERSMITH  
LONDON W6 0SL  
TEL: 020 8748 4023

*wanted on  
new patient  
don't lead*

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6. Have you ever had a joint replacement or other implant?  
Yes  No
7. Have you ever had a bad reaction to general or local anaesthetic?  
Yes  No
8. Have you taken steroids in the last two years?  
Yes  No
9. Are there any other aspects concerning your health that you think the dentist should know about?  
Yes  No

If "yes" please give details

#### DENTAL HISTORY

1. Do you suffer from any of the following...  
Mouth ulcers? Yes  No   
Cold sores? Yes  No   
Dry mouth? Yes  No
2. Do you take sugar with:  
Tea   
Coffee   
Cereal
- If yes how often and how much?
3. How often do you drink fizzy or fruit concentrate drinks?

4. How often do you eat sweets / sugary snacks?  
Before/After/Between/meals?  
Chocolate   
Yogurt   
Cakes   
Biscuits
5. Do you use anything to clean in-between your teeth?  
Yes  No
- If yes please give details:
6. Do you use any of the following:  
Electric toothbrush   
Dental floss   
Disclosing tablets   
Mouth /gum rinses   
Interdental products
7. Do your gums bleed?  
Yes  No
8. Are you aware if you grind or clench your teeth?  
Yes  No
9. Do you suffer from clicking jaw joints?  
Yes  No
10. Did you suffer from clicking jaw joints in the past and now don't?  
Yes  No
11. Do you suffer from head, neck or shoulder pains?  
Yes  No

12. How long would you like to keep your teeth?  
As long as possible   
For a few years   
Not bothered
13. Are you happy with the appearance of your teeth?  
Yes  No
14. Do you have a preference for a tooth coloured filling on the biting surface of your back teeth?  
Yes  No
15. Do you have any particular anxieties with dental treatment, for example drilling, injections etc?  
Yes  No
16. When did you last attend the dentist and what did you have done?  
please give details.
17. Do you suffer from any recurrent dental / oral problems?  
If yes, please give details.
- Signature: \_\_\_\_\_
- Date: \_\_\_\_\_

#### MEDICAL UPDATES:

- Dates:  
Any change / Further Information :
- Patients Initials :
- Dates:  
Any change / Further Information :
- Patients Initials :
- Dates:  
Any change / Further Information :
- Patients Initials :
- Dates:  
Any change / Further Information :
- Patients Initials :

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