Confidential Medical History Form

Patient Name: .....

Date of Birth: .....

Trinity Dental

Confidential Medical History Form

Please complete all questions

Name ..... Mr/Mrs/Ms/Master/Miss/Dr/Other

Address .....

..... Post Code .....

Phone ..... Mobile .....

Email Address .....

Date of Birth ..... Occupation .....

Doctors Name .....

Doctors Address .....

New Patients

How did you hear about the clinic? ☐ Friends/Family ☐ Yellow Pages ☐ Internet/Website

If another please advise .....

Did any of your friends/family recommend you to Trinity Dental for treatment? .....

What is their name so we may enter them into our referral prize draw? .....

Last Dental Visit? .....

Dental Health

Do your gums bleed while brushing? Yes/No .....

Do you have sensitive teeth? Yes/No .....

Do you clench or grind your teeth? Yes/No .....

Have you ever had a bad experience at the dentist (if yes, provide details below) .....

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Trinity Dental

Dental Health

Do you feel generally healthy?	Yes/No	.....
Do you have any heart complaints?	Yes/No	.....
Have you ever had liver disease, jaundice, hepatitis or kidney disease?	Yes/No	.....
Do you suffer from bronchitis, asthma or any other chest condition?	Yes/No	.....
Do you have diabetes?	Yes/No	.....
Do you have bone or joint disease, arthritis or osteoporosis?	Yes/No	.....
Do you suffer from epilepsy or fainting attacks?	Yes/No	.....
Have you ever had a blood transfusion since 1st Jan 1980?	Yes/No	.....
Is there a history of CJD in your family?	Yes/No	.....
Are you allergic to any medicines, food or material, eg. Latex?	Yes/No	.....
Have you taken steroids within the last two years?	Yes/No	.....
Have you ever had a bad reaction to general or local anaesthetic?	Yes/No	.....
Do you have any other serious illness or infectious disease?	Yes/No	.....
Are you currently or have you ever taken Bisphosphonates?	Yes/No	.....

Please list any medication you are currently taking

.....

.....

Mouth Cancer Risk Assessment

Alcohol intake weekly (Units) .....

Smoking (How many Daily) .....

Do you or have you ever taken recreational drugs? .....

WOMEN ONLY

Are you currently or possibly pregnant?	Yes/No	.....
Are you taking oral contraceptives or HRT?	Yes/No	.....
Are you breast feeding?	Yes/No	.....

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Smile Evaluation

Please tick the relevant boxes to help us know your current dental concerns

	Yes	No
Do you have crooked teeth?	☐	☐
Do you have any noticeable spaces between your teeth?	☐	☐
Are you missing any teeth?	☐	☐
Would you like your teeth to look whiter or brighter?	☐	☐
Do you have any old crowns that now do not match other teeth or have dark lines at the gums?	☐	☐
Do you have any old or stained fillings that show when you smile?	☐	☐
Do you have any silver fillings that you prefer were tooth coloured?	☐	☐
Do your gums bleed when brushing?	☐	☐
Are you self conscious about your smile?	☐	☐
Do you find yourself not smiling in photos or covering your teeth with your hands or lips?	☐	☐

Patient signature ..... Date .....

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