30 BEAUMONT STREET

DU TOIT WINTER MOLYNEUX

30 Beaumont Street · Oxford · OX1 2NY · 01865 552978

CONFIDENTIAL MEDICAL AND DENTAL HISTORY

To provide you with the best and safest care, we need to know of any factors which may affect your treatment. Please answer every question and tick whichever box applies. If you wish to add any further comments, please use the space provided at the end of this form. Your answers are for our records only and will be treated in the strictest confidence.

Title.....

Last Name.....

First Name(s).....

Date of Birth.....

Occupation.....

Home Address.....

.....

..... Postcode.....

Email Address.....

Telephone.....

Mobile.....

Emergency contact.....

.....

Mobile.....

Telephone.....

Doctor's Name.....

Doctor's Address.....

.....

.....Postcode.....

Which is your preferred contact method?

.....

.....

MEDICAL HISTORY

	YES	NO
Have you suffered from any ill health in the last six months?	☐	☐
Are you presently under medical care?	☐	☐
Are you taking any medication?	☐	☐
Have you ever had a prolonged or serious illness?	☐	☐
Have you ever had surgery or radiation therapy?	☐	☐
Have you ever had any heart problems - for example; Rheumatic fever, Heart murmur, Cardiac pacemaker, Heart Attack, Angina, raised or lowered blood pressure?	☐	☐
Have you ever had chest problems - for example; Asthma or other breathing difficulties ?	☐	☐
Do you smoke, or have you smoked in the past?	☐	☐
Have you ever had any serious illnesses, for example; Jaundice, Hepatitis, Diabetes, Epilepsy, Stomach Ulcers?	☐	☐

	YES	NO
Do you have any serious bleeding disorders?	☐	☐
Do you carry a warning card?	☐	☐
Have you had any joints replaced?	☐	☐
Do you have any allergies?	☐	☐
Are you pregnant?	☐	☐

DENTAL HISTORY

	YES	NO
Does anything concern you about your dental health at the moment?	☐	☐
Do you ever have pain on chewing or biting?	☐	☐
Are you happy with the appearance of your teeth and fillings?	☐	☐
Do your gums bleed on brushing?	☐	☐
Have you seen a Dental Hydienist in the past?	☐	☐
Have you ever had any problem with local anaesthetics?	☐	☐
Do you suffer from tension headaches or migraines?	☐	☐
Are you aware of tension, clicking or popping in your jaw?	☐	☐

Are you happy for us to leave a message in relation to opportunities with a 3rd party?	☐	☐

How did you hear of our practice? .....

Is there anything else you would like to mention? (Please continue below if necessary)	☐	☐

.....

.....

Signed Date