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# 30 BEAUMONT STREET

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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.....	Emergency contact.....
Last Name.....	.....
First Name(s).....	Mobile.....
Date of Birth.....	Telephone.....
Occupation.....	Doctor's Name.....
Home Address.....	Doctor's Address.....
.....	.....
..... Postcode.....	..... Postcode.....
Email Address.....	Which is your preferred contact method?
Telephone.....	.....
Mobile.....	.....

## MEDICAL HISTORY

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

	YES	NO
Do you have any serious bleeding disorders?	<input type="checkbox"/>	<input type="checkbox"/>
Do you carry a warning card?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any joints replaced?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

### DENTAL HISTORY

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

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Are you happy for us to leave a message in relation to opportunities with a 3rd party?	<input type="checkbox"/>	<input type="checkbox"/>
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How did you hear of our practice? .....

Is there anything else you would like to mention? (Please continue below if necessary)	<input type="checkbox"/>	<input type="checkbox"/>
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**Signed**

**Date**