CHURCH STREET DENTAL PRACTICE
The Dental Practice That Cares

Church Street Dental Practice Medical History

Please complete the medical form below. Please ensure all medications are listed.

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Full Name:..**DOB:**.......................................

Address (incl. post code): ....

Email address:..**Telephone:** ....

Emerg Contact (incl nº):...

GP address:..

School/Occupation:..

Are you:	**Yes**	**No**	**Do You:**	**Yes**	**No**
Currently attending/waiting to see a Doctor, Hospital Consultant or specialist?			Take Warfarin/ Bisphosphonates?		
Taking any medication, inhalers, creams, injections or patches? (Please detail name and dosage - provide prescription if possible)			Have any auto-immune disorders?		
			Suffer from any allergies e.g. antibiotics/foods/latex etc? (Please detail)		
Pregnant or possibly pregnant?			Carry a medical warning card?		
Have you:	**Yes**	**No**	Use a wheelchair and/or have mobility impairment?		
Taken steroid tablets in the last 3 months			**Have you ever suffered from:**	**Yes**	**No**
Ever had a general anaesthetic/surgery?			Angina or had a heart attack/surgery?		
			Asthma/Bronchitis?		
Ever suffered from Sepsis?			Excessive bleeding after dental extractions?		
Have you ever suffered from:	**Yes**	**No**	Jaundice/Hepatitis and/or HIV?		
Any condition that affects your bones or joints?			Epilepsy and /or seizures? Type & date of last seizure?		
Endocarditis and/or Rheumatic fever			Tuberculosis (TB)		
High blood pressure?			Learning Disabilities and/or Autism		
Hemophilia/blood disorder/sickle cell			Hearing or Visual impairment?		
Diabetes or a family history of? Do you control this with diet, tablets or insulin?			**Do you?**		
Any mental health disorders?			Do you smoke/vape?		
			How many per day?		
Have you had a history of CJD or other prion disease in your family?			How many units of alcohol do you drink per week? (A unit is half a pint of lager, a single measure of spirits)		
Any other condition/information not already mentioned:					

My contact preference is (please circle): **Text** **Call** **Email** **Post**

I consent to receive timely updates from the practice with any news and information: **Yes** **No**

Date: ....**Patient Signature:** ....**Dentist Signature:** ....

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Optional – Smile Profile

- **What do you like best about your smile?**

- **What do you like least about your smile?**

Please select the statements you consider to be true:

	I wish my teeth were whiter
	I wish I had a wider smile
	I am unhappy with the shape of my teeth
	I think my teeth are too large/small
	I wish my teeth were straighter
	I think my gums show too much when I smile
	I do not smile because of my teeth
	I wish the gaps in between my teeth were smaller
	I don't know what my dentist can do in order to improve my smile
	I am concerned that I could not afford the dentistry that I would like
	I hate the black fillings in my mouth
	I wish my teeth were all the same colour
	I am worried about the cracks in my teeth
	I would like more information on line and wrinkle treatment
	How important is keeping your teeth? Please circle… 1 being the lowest and 10 the highest… 1 2 3 4 5 6 7 8 9 10
	Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10
	I suffer with headaches/jaw pain
	I have a click in my jaw
	I have discomfort when chewing
	I have fractured teeth in the past
	I am aware of clenching/grinding my teeth
	I would like to improve my lines and wrinkles
	I would like to enhance my lips

- **What are you hoping to achieve from your dental visit today?**

- **What are your expectations of us?**