Church Street Dental Practice Medical History - Please ensure all medications are listed.

Full name:		**Date of Birth:**	
Address incl post code:			
Email Address:		**Telephone:**	
Emerg Contact (incl. n°):			
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?**	**Yes**	**No**
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:

Consent:	**Yes**	**No**
GDPR consent: I consent to receive timely updates from the practice with any news and/or information about services that we provide or introduce such as additional clinics or treatment offers	☐	☐
Clinical Photography Consent: I agree to have clinical photographs taken of my teeth - these images could be used in any media including print and digital media formats such as print publications, brochures, websites, e-marketing, posters, banners, advertising, film, social media, teaching and research purposes. I understand my identity will be protected at all times and my name and personal details will not be shared or published. I have read and understand the conditions and consent to my images and or video recordings being used as described. **I understand by agreeing, this acts as ongoing consent that I can withdraw at any time.**	☐	☐
My contact preferences are (tick or circle): **Email** ☐ **Text** ☐ **Call** ☐ **Post** ☐		

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

Smile Profile Questionnaire

What do you like best about your smile?

What do you like least about your smile?

What are you expecting from your visit today?

Health of my teeth and gums:

How important are your teeth to you? **Please circle** (1 being the lowest and 10 the highest)

1	2	3	4	5	6	7	8	9	10

How would you rate your current dental health?

1	2	3	4	5	6	7	8	9	10

☐	I think my gums show too much when I smile
☐	I notice bleeding when I brush my teeth

Comfort:

☐	I suffer with headaches/jaw pain
☐	I have discomfort when chewing
☐	I have a click in my jaw
☐	I have fractured teeth in the past
☐	I am aware of clenching/grinding my teeth
☐	I currently wear a mouth guard

Colour/shade of my teeth:

☐	I wish my teeth were whiter
☐	I wish my teeth were all the same colour
☐	I hate the black fillings in my mouth

General appearance of my teeth:

☐	I do not smile because of my teeth
☐	I wish my teeth were straighter
☐	I am unhappy with the shape of my teeth
☐	I think my teeth are too large/small
☐	I wish I had a wider smile
☐	I wish the gaps in between my teeth were smaller
☐	I am worried about the cracks in my teeth
☐	I am unsure what treatment is available in order to improve my smile
☐	I am concerned that I could not afford the dentistry that I would like

Facial Aesthetics:

☐	I would like to improve my lines and wrinkles
☐	I would like to enhance my lips
☐	I would like more information on facial aesthetics and the treatment options available