THE STAINES CENTRE OF
DENTAL EXCELLENCE

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periodontics ■ endodontics ■ oral surgery ■ sedation ■ implants ■

medical history form

To obtain the best and safest treatment, we need to know of any conditions which may affect your treatment

First Name Surname

Date of Birth Sex Male ☐ Female ☐

Address

Tel (Home) (Work/Mobile) Occupation

Email Address

Your Doctor's Name and Address

By which method would you like to be reminded of your appointments: SMS Text Message ☐ Letter ☐

I am interested in the following services: Dental Implants ☐ Cosmetic Dentistry ☐ Sedation ☐ Invisible Braces ☐

How would you score your smile out of 10: ☐ 1= very unhappy 10= very happy

How anxious are you of dental treatment out of 10: ☐ 1= very anxious 10= not at all

	Yes	No	Details
Have you attended or received treatment from a doctor, hospital, clinic or specialist in the last two years?			
Do you have a pacemaker fitted or have you had any form of heart surgery?			
Do you suffer from any allergies?			
Do you take steroids?			
Have you ever suffered from excessive bleeding?			
Do you bruise easily?			
Have you ever had any blood tests e.g. Hepatitis B, Hepatitis C, HIV?			
Could you be pregnant or are you currently breastfeeding?			
Do you suffer from any serious illness?			
Do you take recreational drugs?			

Have you suffered from?	Yes	No		Yes	No
Heart attack			Kidney disease		
High blood pressure			Diabetes		
Chest pains			Thyroid problems		
Abnormal heart beat			Arthritis		
Shortage of breath e.g. lying down, walking and/ or climbing stairs			Ulcers		
Anaemia			Hiatus Hernia		
Swollen Ankles			Myasthenia Gravis		
Rheumatic Fever			Epilepsy		
Asthma			Fainting or dizzy spells		
Bronchitis			Sickle Cell disease or trait		

Please list any medication you are taking (including tablets, creams, herbal remedies etc)

How many units of alcohol do you drink in a week? Do you smoke? If so, how many per day?

For those patients requiring treatment under sedation	Yes	No	Details
Have you ever had a sedation before? Please state what type? Tablets, Gas and Air, Injection in arm or hand, Other.			
If so, did you experience any problems?			
Have you ever had a General Anaesthetic before?			
If so, did you experience any problems?			

Completed by: Self / Parent / Guardian

Patient Signature

Date