**Medical History and Patient Smile Assessment**

**Please take the time to read and fully complete this form, it will enable us to treat you appropriately.**

|  |  |
| --- | --- |
| **Patient Name (Full name including title):** |  |
| **Address:** |  |
| **Date of birth:** |  |
| **Contact telephone numbers:** |  |
| **Email address:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you have/have you had any problems with** | **Yes** | **No** | **Details** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **1.** | **Heart – angina, heart murmur, rheumatic fever, replacement valve, pacemaker or blood pressure?** |  |  |  |
| **2.** | **Chest – Asthma, bronchitis, breathlessness, or persistent cough?** |  |  |  |
| **3.** | **Sleep Apnoea?** |  |  |  |
| **4.** | **Circulation and blood – anaemia, prolonged bleeding following cuts or extractions, sickle cell disease or thalassaemia?**  |  |  |  |
| **5.** | **Stomach and intestine – ulcers, reflux, colitis, jaundice, cirrhosis, of the liver?**  |  |  |  |
| **6.** | **Kidneys – chronic infections or renal failure?** |  |  |  |
| **7.** | **Nervous system – epilepsy, Parkinson’s disease, multiple sclerosis, stroke, fainting attacks, shunts, psychological illness or depression?** |  |  |  |
| **8.** | **Hormonal system – diabetes or thyroid?** |  |  |  |
| **9.** | **Joints and bones – arthritis, osteoporosis?** |  |  |  |
| **10.** | **Congenital condition – cerebral palsy, downs syndrome, cystic fibrosis, or spina bifida?** |  |  |  |
| **11.** | **Have you ever had any operations or serious illnesses not listed above?** |  |  |  |
| **12.** | **Do you smoke or use other tobacco products?** |  |  | **No. per day:** |
| **13.** | **Chewing paan/betel, areca nut or other?** |  |  |  |
| **14.** | **How many units of alcohol do you consume per week?** |  |  |  **Units** |

**Height: ft inc Weight: St lbs**

**Please tell the dentist or tick here if you are HIV positive**

**Have you had symptoms of COVID 19 Yes/No**

**Has someone in your household has symptoms of COVID 19? Yes/No**

**Have you been diagnosed with COVID 19? Yes/No**

**Please list all medications or provide reception with your repeat prescription to be scanned:**

**Emergency contact details:**

**Name: Relationship:**

**Contact number:**

**Doctors Surgery Name & contact number:**

**Please consider the following statements carefully and circle your response.**

|  |  |  |
| --- | --- | --- |
| **I am concerned about the appearance of my teeth** | **Yes** | **No** |
| **I am interested in tooth whitening treatments** | **Yes** | **No** |
| **I am interested in removable aligner treatments**  | **Yes** | **No** |
| **I would like to discuss the shape of one or more of my teeth** | **Yes** | **No** |
| **I have old fillings and would like to replace them with white fillings** | **Yes** | **No** |
| **I have had previous dental treatment that is no longer satisfactory** | **Yes** | **No** |
| **I wish to discuss anti-wrinkle treatments/dermal fillers** | **Yes** | **No** |
| **I wish to discuss options to fill gaps (i.e. dentures, bridges, implants)** | **Yes** | **No** |

**Please use the following space to write anything you would like to discuss with your dentist:**

**Signed: Date: / /**