wyndham house
dental practice

Medical History Form

All information will be treated in the strictest confidence

Personal Details

Surname: Forename(s):

Date of Birth:

Medical Information

Doctor's Name, Surgery Address and Telephone:

Are you:

Pregnant Yes / No If so when is your due date:

Receiving treatment from a doctor Yes / No Please give brief details:

Taking any prescribed medicines Yes / No Please supply details:

Carrying a medical warning card Yes / No

Do you suffer from:

Allergies to any medicines / substances Yes / No If so please supply details:

Hay Fever	Yes / No	Eczema	Yes / No
Bronchitis	Yes / No	Asthma	Yes / No
Other Chest Condition	Yes / No	Fainting Attacks	Yes / No
Angina	Yes / No	High/Low Blood Pressure	Yes / No
Diabetes	Yes / No	Infectious Diseases (including HIV / Hepatitis)	Yes / No
Epilepsy	Yes / No	Bleeding disorders	Yes / No

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Drinking and Smoking

Alcohol, nicotine and other substances smoked, as well as having a detrimental effect on ones health as a whole, can have a very specific effect on the gums and oral skin / mucosa making some procedures ill-advised and unsuccessful and putting the patient at risk of serious diseases.

How many units of alcohol do you drink per week?
(A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitif)_____Units per Week

How many tobacco products do you smoke per day?_____

Dentistry and you

Please supply any additional information which you think might be relevant

Examples: "I don't like to go too far back in the chair"
"The last time I had local anaesthetic it made me feel a bit shaky"
"I have had all my previous dental work carried out under sedation"

Are you a regular dental attender? Yes / No Are you happy with your smile? Yes / No

Are there any specific areas of dentistry which interest you? For example:

	Please tick
Cosmetic Dentistry	
Implants	
Gum Treatments	
Tooth Whitening	
Sedation	
Other (please specify)	

Important

You must inform your dentist if there are **ANY** changes to your medical condition, general health or if you change or start taking any medication not mentioned above.

Signature: Print Name:

Date

Many thanks for taking the time to complete this questionaire