LONDONCITYSMILES.COM
DENTAL IMPLANTS SAME-DAY TEETH COSMETIC DENTISTRY WHITENING ORTHODONTICS

PATIENT PERSONAL INFORMATION

Mr / Mrs/ Ms/Miss/Dr/ Other

Surname.....

First Name .....

Date of Birth .....

Occupation.....

Home Address .....

.....

.....

Post Code .....

Mobile Phone.....

Home Phone... .....

Work Phone.....

E-mail .....

GP'S Address.....

.....

.....

Post Code .....

GP Phone No.....

NHS number .....

Communication Preferences

□Email □ Post □SMS

MEDICAL HISTORY – PRIVATE AND CONFIDENTIAL

For the following questions please **CIRCLE YES or NO**. Your answers are for records only and will be considered confidential. This questionnaire is essential to enable us to take appropriate steps to safeguard your health.

YES NO Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?
Details.....
YES NO Have you been hospitalised recently?
Details .....
YES NO Have you taken steroids in the last 2 years?
YES NO Are you taking any medicines, tablets, drugs or injections or using any creams, ointments or inhalers?
YES NO Carrying a medical warning card?
YES NO Pregnant/Nursing Mother

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

YES NO High or low blood pressure?
Details .....
YES NO Rheumatic fever or chorea
YES NO Heart Murmur
YES NO Stroke or Paralysis
YES NO Artificial Heart Valve or Pacemaker
YES NO Angina
YES NO Asthma/ Bronchitis
YES NO Hay fever or eczema
YES NO Brain surgery or Neurological (nerve) diseases
YES NO Arthritis
YES NO HIV
YES NO Hepatitis / Jaundice/Liver or Kidney disease
YES NO Fainting attacks/giddiness/blackouts or epilepsy

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

YES NO Latex
YES NO Penicillin
YES NO Aspirin
YES NO Local anaesthetics

ANY OTHER ALLERGIES?

YES NO .....

DIABETES

YES NO Do you suffer from diabetes?
If the answer is yes is it controlled by:
DIET TABLETS INSULIN

OTHER
YES NO Do you have osteoporosis?
YES NO Do you bleed a lot when you cut yourself?
YES NO Do you bruise easily?
YES NO Do you suffer from anaemia?

YES NO Does any member of your family have bleeding disorder?

YES NO Have you had a hip or a joint replacement?

YES NO Have you had a bad reaction to a local or general anaesthetic?

PLEASE LIST ANY MEDICINES YOU ARE TAKING:

.....
.....
.....
.....

YES NO Do you ever get cold sores?
YES NO Do you smoke?
If yes how many a day?.....
YES NO Do you drink?
If yes how much weekly?.....
(1 unit = ½ pint of beer, 1 glass of wine, 1 measure of spirit)

THIS FORM HAS BEEN COMPLETED BY :

SELF/GUARDIAN/PARENT/DENTIST

SIGNED: .....

DATE: .....

Dentist's Signature:.....

DATE:.....