

Confidential Medical History Form

We ask you for information about your general health to help us treat you safely. Please fill in your details below, answer the health questions, and then sign the form on the back page. We will use this form at later visits to discuss any changes in your general health. All information will be kept strictly confidential.

Surname _____ **Title** _____

First Name(s) _____ **Date of Birth** _____

Your occupation _____

Your GP's Name and Address _____

Are you currently	Yes	No	Please give details
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines? (eg tablets, ointments, injections or inhalers, including contraceptives and HRT) – Please list			
Carrying a medical warning card?			
Pregnant?			
Do you suffer from	Yes	No	Please give details
Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?			
Hay fever or eczema?			
Bronchitis, asthma or other chest condition?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart problems, angina, blood pressure problems or stroke?			
Diabetes (yourself or a blood relative)?			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases (including cold sores, HIV and hepatitis)?			
Have you ever had	Yes	No	Please give details
Rheumatic fever or cholera?			
Liver disease (eg jaundice, hepatitis) or kidney disease?			
Any other serious illness? (eg cancer)			

Priory Dental Care New Patient Questionnaire



Welcome to Priory Dental Care. To enable us to offer you the best possible service, and to help us understand your treatment needs, please could you kindly complete the following questionnaire.

Patient Name: _____ **Date of Birth:** _____

1) How long since your last dental visit? _____ years _____ months

2) What is the main reason for your visit today? (please give details below)

3) Are you experiencing any pain or discomfort in your mouth? Yes No
(if answering 'Yes' please give further details below)

4) Do your teeth allow you to eat an unrestricted diet? Yes No
(if answering 'No' please give further details below)

5) How do you feel about the appearance of your teeth? Satisfied Dissatisfied
(if answering 'Dissatisfied' please give further details below)

6) Have you ever had any problems with dental treatment? Yes No
(if answering 'Yes' please give further details below)

7) Are you looking for regular dental care, or just a one-off treatment? Regular One-off

8) Once 'dentally fit', are you interested in joining our monthly payment plan (Denplan)? Yes No

9) Is there anything else you wish to tell us? (please give details below)