HOLLAND PARK
DENTAL CENTRE

CONFIDENTIAL MEDICAL HISTORY

170 HOLLAND PARK AVENUE

LONDON W11 4UH

0207 603 4155

WWW.HOLLANDPARKDENTAL.CO.UK

Personal Details

Title: First Name: Surname:

DOB: / / Sex: M / F

Address:

Postcode:

Home tel: Mobile tel:

Email:

Occupation:

Next of Kin: relationship:

Contact tel:

Doctor's name: Doctor's surgery:

Doctor's tel:

When did you last receive dental treatment?

Previous dentist:

How did you hear about the practice? WOM / google search / referred / social media / other

Referred by / other:

Medical History

Are you?	**Yes / No**	**Details**
currently receiving treatment by a doctor, hospital or clinic?	Yes / No	
taking any prescribed medication? (e.g tablets, inhalers, contraceptives)	Yes / No	
taking or have taken steroids in the past 2years?	Yes / No	
carry a medical warning card?	Yes / No	
Do you suffer from?		
any allergies? (e.g. penicillin), substances (e.g. latex/rubber) or foods?	Yes / No	
Hay fever or eczema or any other allergy?	Yes / No	
Bronchitis, asthma or other chest condition?	Yes / No	
Fainting attacks, giddiness, blackouts, epilepsy?	Yes / No	
Heart problems, angina, blood pressure problems, or stroke?	Yes / No	
Diabetes? (or anyone in your family)	Yes / No	
Arthritis?	Yes / No	
Bruise easily or suffer persistent bleeding following a tooth extraction or injury?	Yes / No	
Any infectious diseases (including HIV and hepatitis)?	Yes / No	
are you currently pregnant or had a baby in the past 12 months?	Yes / No	

Did you as a child or since, have:		**Details**
Rheumatic fever or chorea?	Yes / No	
Liver disease (e.g. jaundice, hepatitis) or kidney disease?	Yes / No	
Any other serious illness?	Yes / No	
A bad reaction to general or local anaesthetic?	Yes / No	
A joint replacement or other implant?	Yes / No	
received treatment that required you to be in hospital?	Yes / No	
A pacemaker, heart surgery or brain surgery?	Yes / No	
Growth hormone treatment before the mid-1980s?	Yes / No	
A close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease (C.JD)?	Yes / No	
Ever had your blood refused by the Blood Transfusion Service?	Yes / No	

Please give any other details which your dentist might need to know about, such as self-prescribed medicines(e.g. aspirin)

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

Smoking		**Quantity**
Do you smoke any tobacco products now (or did you in the past)? How many times per day?	Yes / No / in past	
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)? How many times per day?	Yes / No / in past	

Declaration and consent

* please delete as appropriate

I *do not / consent to being contacted via email.

I *do not / consent to voicemails being left on my *home / *Mobile / *work telephone.

I *do not / consent to clinical photographs of myself to be used in teaching, practice marketing / advertisment publications and online.

I certify that I have read and understood the questionnaire I have completed and that the answers I have given are, to the best of my knowledge, true and factually accurate.

Name: **Signature:** **Date:**

self / parent / guardian

Dentist: **Signature:** **Date:**

reviewed by dentist

SMILE

MY EVALUATION

Are you satisfied with your teeth and their appearance?	Yes / No
Are you self conscious about your teeth when you smile?	Yes / No
Would you like your teeth whiter?	Yes / No
Do you have any irregularly positioned teeth which you dislike?	Yes / No
Do you have any discoloured teeth which embarrass you?	Yes / No
Do your front teeth have fillings which do not match the colour of your teeth?	Yes / No
Would you like your teeth to be straighter?	Yes / No
Do you have space between your teeth that you do not like?	Yes / No
Do you suffer from bad breath - halitosis?	Yes / No

If you could alter your smile what would you most like to change?

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